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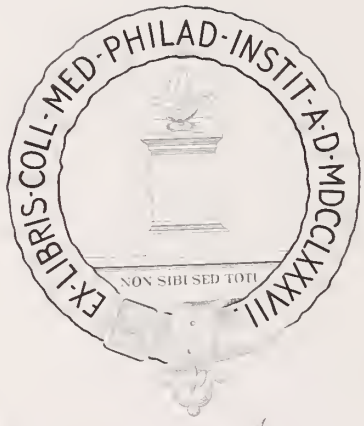

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JANUARY 1981

Membership Directory: 1980-81

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*Present as 345.9 mg. and 691.8 mg. of the calcium salt of fenoprofen dihydrate equivalent to 300 mg. and 600 mg. fenoprofen respectively.

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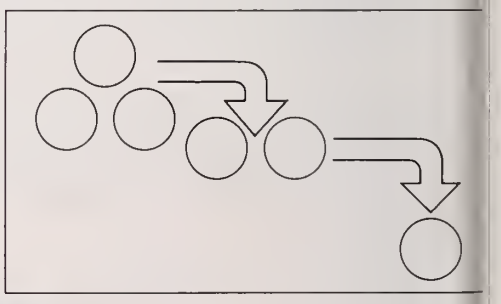
Ensures smooth therapeutic effect even if a dose is missed The relatively longer half-life of Valium* (diazepam/Roche) has important clinical and pharmacological implications. Steady-state levels generally are reached within 5-7 days with no further accumulation. At this plateau, the patient benefits from the consistent, steady response you expect. Sharp blood level variations, frequently attributed to agents with a short half-life, do not appear with Valium.

Avoids sudden symptom breakthrough Once steady-state levels are achieved, sudden reemergence of symptoms is unlikely. Diazepam and its active metabolites exhibit overlapping half-lives that are advantageous not only during therapy but especially when pharmacologic support is discontinued. Elimination rates are gradual with Valium and thus provide a compatible adjustment interval for the patient. In comparison, blood levels of short-acting agents with inactive metabolites decrease more rapidly and are more likely to be associated with withdrawal symptoms if medication is stopped abruptly.* With Valium unwanted effects other than drowsiness or ataxia are rare. Patients should be cautioned about driving and advised to avoid alcohol.

Tapers naturally; complements gradual dosage reduction at discontinuation When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



in the management of symptoms of anxiety

Valium® (IV)

diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

effective therapy through efficient pharmacodynamics

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Before prescribing, please see summary of product information on next page

Valium® IV
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies The physician should periodically reassess the usefulness of the drug for the individual patient
Contraindicated: Known hypersensitivity to the drug Children under 6 months of age Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy gradually taper dosage Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics barbiturates MAO inhibitors and other antidepressants may potentiate its action Usual precautions indicated in patients severely depressed or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness confusion, diplopia, hypotension, changes in libido nausea fatigue, depression, dysarthria jaundice, skin rash, ataxia constipation headache incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy

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State Medical Society of Wisconsin

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Created by the Territorial Legislature in 1841 . . . Representing nearly 5,000 member physicians in Wisconsin, comprising 55 county medical societies and 23 medical specialty sections, with all members belonging to the American Medical Association. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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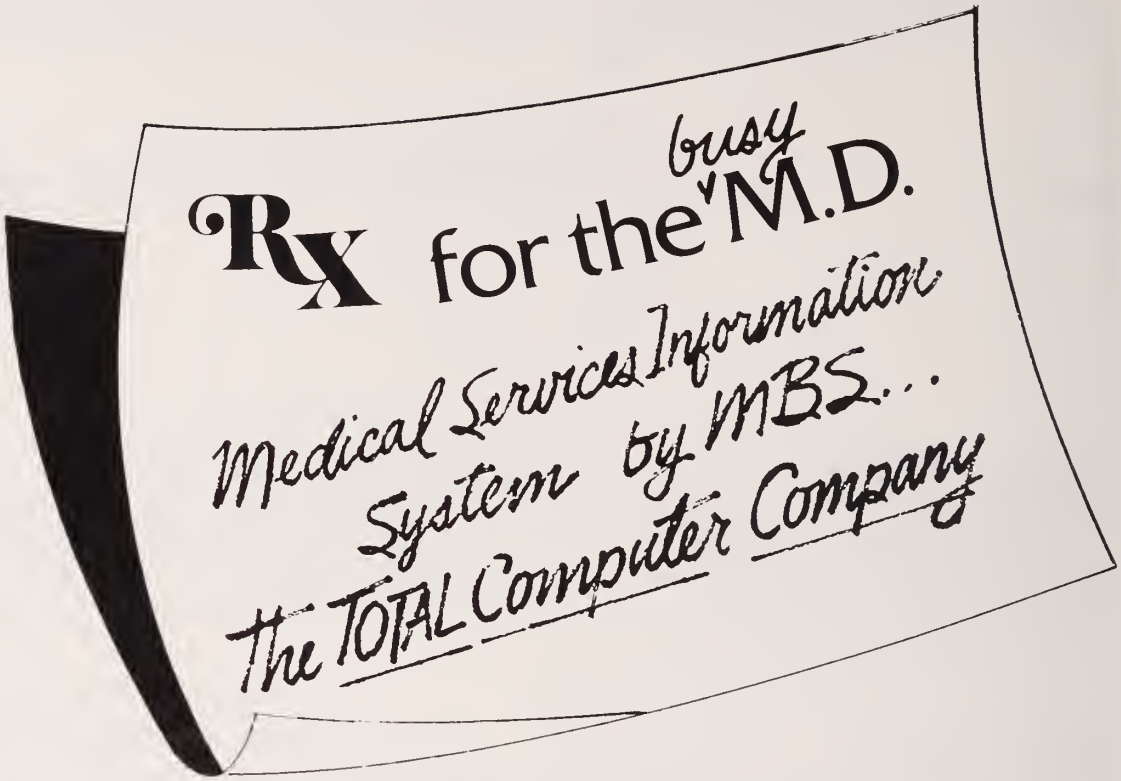
March issue: Special articles on mental health.

WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

JUN 23 1982



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An incredible increase in billing, collection and insurance red tape has spread like a plague over the medical profession. It especially includes governmental excesses that attack doctors like a viral infection.

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You can usually recognize this illness by the number of hours you are involved with paper work or the number of secretaries involved with your paper work. It is a gradual, debilitating process that will allow you less and less time to spend with your patients. It will insidiously cause your bookkeeping and secretarial costs to feverishly rise to a painful level.

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All information is preprogrammed to be compati with reporting requiremen of government agencies an private health carriers incl ing daily Insurance forms. Once a month, each doctor office receives itemized Su Bills ready for mailing.

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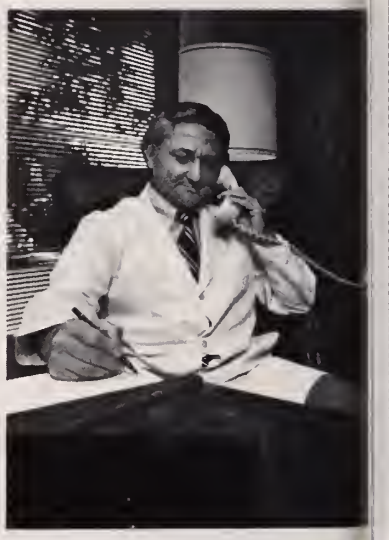

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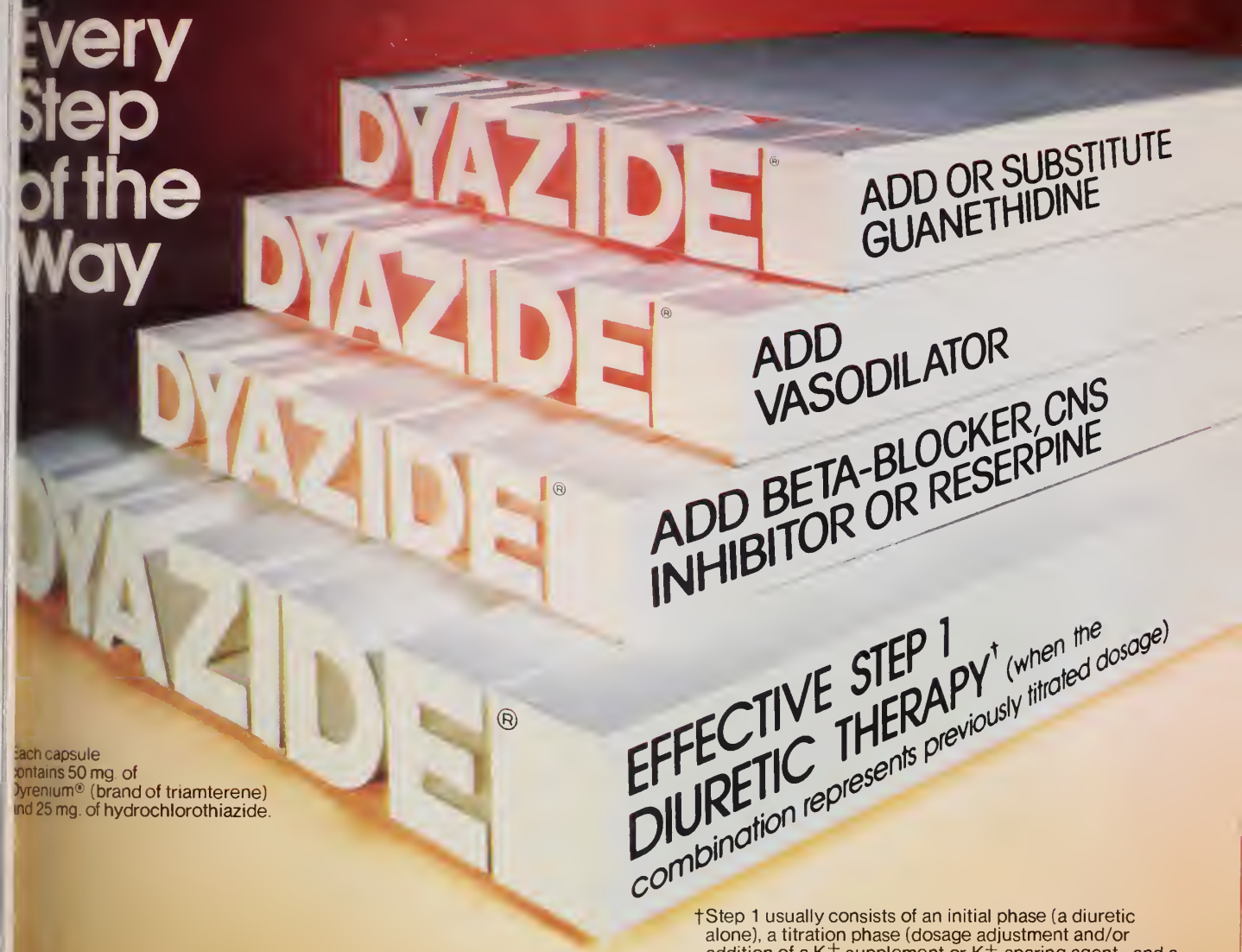

Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

WARNING
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia, pre existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in postsympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

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References: 1. Paulsan GW *NY State J* 79: 193-195, Feb 1979. **2.** Hallister LE Antipsychotic medications and the treatn schizophrenia, chap. 9, in *Psychopharm from Theory to Practice*, edited by Barch *et al.* New York, Oxford University Press, pp 134, 145. **3.** Damina EF: Antipsycho phenothiazines, thioxanthenes, butyroph and rauwolfia alkaloids, chap. 25, in *Dr Pharmacology in Medicine*, ed.4, edited DiPalma JR. New York, McGraw-Hill Boo Company, 1971, p.476. **4.** Savner R, DE Extrapyramidal syndromes and other ne side effects of psychotropic drugs, in *Ps pharmacology: A Generation of Progress* Lipton MA, DiMascia A, Killam KF. New Raven Press, 1978, p.1021. **5.** Donlon Stenson RL: *Dis Nerv Syst* 37: 629-635 1976.

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Please see summary of product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy.

Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) — bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50.

ROCHE®

ROCHE PRODUCTS INC
Manati, Puerto Rico 00701

Your guide to patient management... when you decide medication is needed

How to initiate and maintain therapy

Select dosage strength appropriate for each patient

- Limbitrol 5-12.5 is recommended to minimize drowsiness and for elderly patients
- Limbitrol 10-25 may be indicated for patients who tolerate medication without undue side effects

Specify daily dosage based on symptom severity

- An initial dosage of three tablets is recommended
- Dosage may be increased to six tablets or decreased to two tablets daily as necessary
- Once a satisfactory response is obtained, patients should be continued on the smallest dose required to maintain the desired effect

Utilize dosage options to best accommodate individual patient needs

- T.I.D. or Q.I.D., familiar regimens most suited for patients who tolerate medication without undue drowsiness
- Two tablets one hour before bedtime and one tablet midday may minimize daytime drowsiness and help relieve a common target symptom — insomnia
- Entire dosage h.s. to take maximum advantage of the sedative effect

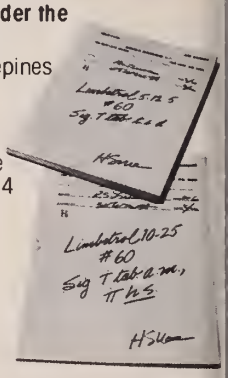
How to make each patient an informed patient

1. Discuss with patients the probability that they will experience drowsiness, especially during the first week.
2. Reassure your patients that drowsiness is one indication that the medication is working and that it may help alleviate their insomnia.
3. Encourage patients to report if drowsiness becomes troublesome so that, if necessary, dosage schedule can be adjusted.
4. Caution patients about the combined effects with alcohol or other CNS depressants. Let them know that the additive effects may produce a harmful level of sedation and CNS depression.
5. Caution patients about activities requiring complete mental alertness, such as operating machinery or driving a car.
6. Warn pregnant patients and patients of childbearing age that the safety of Limbitrol in pregnancy has not yet been established.

Please see complete product disclosure for other pertinent informat

Limbitrol should not be used under the following circumstances:

1. Hypersensitivity to benzodiazepines or tricyclic antidepressants.
2. Concomitantly with an MAO inhibitor. To replace an MAO inhibitor with Limbitrol, discontinue MAO inhibitor for a minimum of 14 days before cautiously initiating Limbitrol therapy.
3. During the acute recovery phase following myocardial infarction.



In moderate depression and anxiety

Limbitrol®

Relief without a phenothiazine

STATE MEDICAL SOCIETY OF WISCONSIN

1980-1981

Membership Directory

as of December 31, 1980

Listed by county medical society in alphabetical order.

This directory includes member's name, address, telephone number, and primary and secondary specialties. Every effort was made to provide accurate listing. Members received a postcard for return to the Journal office for verification of information provided by the Membership Department. Telephone numbers are included when provided by members.

In the event of inaccuracies members are asked to contact the Journal office for inclusion in an UPDATE section of subsequent issues of the Journal.

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Box 1109, Madison, Wisconsin 53701

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$25.00 to others

Key to CITIES in COUNTY MEDICAL SOCIETIES

City *County Medical Society / ies*

Adams—Adams
Adell—Sheboygan
Algoma—Door/Kewaunee
Alma—Trempealeau/Jackson/Buffalo
Altoona—Eau Claire/Dunn/Pepin
Amery—Polk
Antigo—Langlade
Appleton—Outagamie, Winnebago
Arcadia—Trempealeau/Jackson/Buffalo
Arkansaw—Pierce/St Croix
Ashland—Ashland/Bayfield/Iron

Baldwin—Pierce/St Croix
Baraboo—Sauk
Barron—Barron/Washburn/Burnett
Bayside—Milwaukee
Beaver Dam—Dodge, Jefferson
Belgium—Milwaukee, Ozaukee
Belleville—Dane
Beloit—Rock
Berlin—Green Lake/Waushara
Black Earth—Dane
Black River Falls—Trempealeau/Jackson/Buffalo
Blair—Trempealeau/Jackson/Buffalo
Bloomer—Chippewa
Bonduel—Shawano
Boscobel—Grant
Brillion—Calumet
Brookfield—Milwaukee, Waukesha
Brooklyn—Green, Dane
Brownsville—Fond du Lac
Bruce—Rusk
Burlington—Kenosha, Milwaukee, Racine
Butte Des Morts—Winnebago

Cadott—Chippewa
Caledonia—Racine
Cambridge—Jefferson
Campbellsport—Fond du Lac
Casco—Door/Kewaunee
Cassville—Grant
Cedarburg—Ozaukee
Cedar Grove—Jefferson
Chetek—Barron/Washburn/Burnett
Chilton—Calumet
Chippewa Falls—Chippewa, Eau Claire/Dunn/Pepin
Clam Lake—Dane
Clear Lake—Polk
Clintonville—Waupaca
Colby—Clark
Columbus—Columbia/Marquette/Adams, Dodge, Jefferson
Cornell—Chippewa
Crandon—Forest
Crivitz—Marinette/Florence
Cross Plains—Dane
Cuba City—Grant
Cudahy—Milwaukee
Cumberland—Barron/Washburn/Burnett

DeForest—Dane
Delafield—Milwaukee, Waukesha
Delavan—Walworth
Denmark—Brown
DePere—Brown, Oconto
Dodgeville—Iowa

City *County Medical Society / ies*

Dousman—Waukesha
Durand—Eau Claire/Dunn/Pepin, Trempealeau/Buffalo/Jackson

Eagle—Waukesha, Milwaukee
Eagle River—Oneida/Vilas
East Ellsworth—Pierce/St Croix
East Troy—Walworth, Milwaukee
Eau Claire—Eau Claire/Dunn/Pepin, Chippewa
Edgerton—Rock
Elcho—Langlade
Eleva—Trempealeau/Buffalo/Jackson, Eau Claire/Dunn/Pepin
Elkhart Lake—Sheboygan
Elkhorn—Walworth
Ellsworth—Pierce/St Croix
Elm Grove—Milwaukee, Waukesha
Elmwood—Pierce/St Croix
Elroy—Juneau
Evansville—Rock

Fall Creek—Eau Claire/Dunn/Pepin
Fennimore—Grant
Fond du Lac—Fond du Lac
Fontana—Walworth
Fort Atkinson—Jefferson
Fox Point—Milwaukee
Franklin—Milwaukee
Franksville—Racine, Sauk
Frederic—Polk
Friendship—Columbia/Marquette/Adams

Galesville—Trempealeau/Jackson/Buffalo
Germantown—Waukesha
Gillett—Oconto
Glendale—Milwaukee
Glenfield—Milwaukee
Glenwood City—Pierce/St Croix
Grafton—Ozaukee, Milwaukee
Grantsburg—Burnett
Green Bay—Brown
Greendale—Milwaukee
Greenfield—Marathon, Milwaukee
Green Lake—Green Lake, Winnebago
Greenwood—Clark
Greshem—Shawano

Hales Corners—Kenosha, Milwaukee
Hartford—Washington
Hartland—Milwaukee, Waukesha
Hayward—Sawyer
Hazel Green—Grant
Hewitt—Wood
Hilbert—Calumet
Hillsboro—Vernon
Hollandale—Iowa
Horicon—Dodge
Hortonville—Outagamie
Hubertus—Washington, Milwaukee, Waukesha
Hudson—Pierce/St Croix
Hurley—Ashland/Bayfield/Iron

Iola—Waupaca

City *County Medical Society / ies*

Jackson—Washington
Janesville—Rock
Jefferson—Jefferson
Juneau—Dodge

Kaukauna—Outagamie
Kenosha—Kenosha, Racine
Kewaskum—Washington
Kewaunee—Door/Kewaunee
Kiel—Sheboygan
Kimberly—Outagamie
King—Waupaca
Kohler—Sheboygan

La Crosse—La Crosse
Ladysmith—Rusk
Lake Geneva—Walworth
Lake Mills—Jefferson
Lake Tomahawk—Oneida/Vilas
Lancaster—Grant
Land O'Lakes—Oneida/Vilas
Laona—Forest
Little Chute—Outagamie
Lodi—Columbia/Marquette/Adams
Loyal—Clark
Luxemburg—Door/Kewaunee/Brown

Madison—Dane
Manawa—Waupaca
Manitowoc—Manitowoc
Marathon—Marathon
Markesan—Dodge
Marinette—Marinette/Florence
Marshfield—Wood
Mauston—Juneau
Mayville—Dodge, Milwaukee
Mazomanie—Dane
Medford—Price/Taylor
Menasha—Outagamie, Winnebago
Menomonee Falls—Washington, Waukesha Milwaukee
Menomonie—Eau Claire/Dunn/Pepin
Mequon—Milwaukee, Ozaukee
Merrill—Lincoln
Middleton—Dane
Milton—Rock, Vernon
Milwaukee—Milwaukee, Ozaukee, Washington, Waukesha
Mineral Point—Iowa
Minocqua—Oneida/Vilas
Mishicot—Manitowoc
Mondovi—Trempealeau/Jackson/Buffalo
Monona—Dane
Monroe—Green
Montfort—Iowa
Monticello—Green
Montello—Columbia/Marquette/Adams
Mosinee—Marathon
Mt Calvary—Fond du Lac
Mt Horeb—Dane
Mukwonago—Milwaukee, Waukesha
Muscoda—Grant

Nashotah—Waukesha, Milwaukee
Neenah—Outagamie, Winnebago
Neillsville—Clark
Nekoosa—Wood

City *County Medical Society / ies*

New Berlin—Waukesha, Milwaukee
New Glarus—Green
New Holstein—Calumet
New Lisbon—Juneau
New London—Waupaca
New Richmond—Pierce/St Croix

Oconomowoc—Milwaukee, Waukesha
Oconto—Marinette/Florence, Oconto
Oconto Falls—Oconto
Omro—Winnebago
Onalaska—Dodge, LaCrosse
Oneida—Outagamie, Brown
Osseo—Trempealeau/Jackson/Buffalo, Eau Claire/Dunn/Pepin
Oostburg—Sheboygan, Milwaukee
Oregon—Dane
Orfordville—Rock
Osceola—Polk
Oshkosh—Winnebago
Owen—Clark
Oxford—Columbia/Marquette/Adams

Park Falls—Price/Taylor
Peshtigo—Marinette/Florence
Pewaukee—Waukesha, Milwaukee
Phelps—Oneida/Vilas
Phillips—Price/Taylor
Plain—Sauk
Platteville—Grant
Plum City—Pierce/St Croix
Plymouth—Sheboygan
Portage—Columbia/Marquette/Adams
Port Washington—Ozaukee
Poynette—Dane
Prairie du Chien—Crawford
Prairie du Sac—Sauk
Prescott—Pierce/St Croix
Pulaski—Brown

Racine—Racine, Kenosha, Milwaukee
Random Lake—Sheboygan

City *County Medical Society / ies*

Redgranite—Green Lake/Waushara
Reedsburg—Sauk
Rhinelander—Oneida/Vilas
Rice Lake—Barron/Washburn/Burnett
Richfield—Washington
Richland Center—Richland
Ripon—Fond du Lac, Winnebago
River Falls—Pierce/St Croix
River Hills—Milwaukee
Rosholt—Portage
Rothschild—Marathon

St Croix Falls—Polk
Shawano—Shawano
Sheboygan—Sheboygan
Sheboygan Falls—Sheboygan
Shell Lake—Barron/Washburn/Burnett
Shorewood—Milwaukee
South Milwaukee—Milwaukee
Sparta—Monroe
Spooner—Barron/Washburn/Burnett
Spring Green—Sauk
Spring Valley—Pierce/St Croix
Stanley—Chippewa
Stetsonville—Price/Taylor
Stevens Point—Portage
Stockbridge—Calumet
Stoughton—Jefferson, Dane
Sturgeon Bay—Door/Kewaunee
Sun Prairie—Dane, Dodge
Superior—Douglas
Sussex—Washington

Theresa—Dodge
Thiensville—Ozaukee, Milwaukee
Tomahawk—Lincoln
Three Lakes—Oneida/Vilas, Milwaukee
Tomah—Monroe
Two Rivers—Manitowoc
Turtle Lake—Barron/Washburn/Burnett, Polk

City *County Medical Society / ies*

Union Grove—Racine

Valders—Manitowoc
Verona—Dane
Viroqua—Vernon

Walworth—Walworth
Washburn—Ashland/Bayfield/Iron
Waterford—Racine, Milwaukee
Waterloo—Jefferson
Watertown—Jefferson
Waukesha—Waukesha, Milwaukee
Waupaca—Waupaca
Waupun—Dodge, Fond du Lac
Wausau—Marathon
Wausaukee—Marinette/Florence
Wautoma—Winnebago
Wauwatosa—Milwaukee, Waukesha, Ozaukee
West Allis—Milwaukee
West Bend—Washington
Westby—Vernon
Westfield—Green Lake
West Salem—La Crosse
Weyauwega—Waupaca
Whitefish Bay—Milwaukee
Whitehall—Trempealeau/Jackson/Buffalo
Whitewater—Walworth, Jefferson
Wild Rose—Green Lake
Wind Lake—Kenosha, Milwaukee, Racine
Winneconne—Winnebago
Wisconsin Dells—Columbia/Marquette/Adams, Juneau, Sauk
Wisconsin Rapids—Wood
Withee—Clark
Wonewoc—Juneau
Wood—Milwaukee, Waukesha
Woodruff—Marathon, Oneida/Vilas

MONTHLY UPDATES TO THIS DIRECTORY WILL APPEAR IN SUBSEQUENT ISSUES OF THE *Wisconsin Medical Journal.*

Changes to listings should be noted on the form on the reverse side of this page and returned to the Journal as soon as possible. New members also will be included in the UPDATES.

Space has been provided at the bottom of each page of listings for reader updating.

Key to SPECIALTY CODES

(Shown directly above name, with primary specialty first, followed by secondary specialties)

Primary and secondary specialties in this directory have been reported to the Society by each individual physician listed. This information has not been verified with any other source. It is intended only for use in this directory and does not indicate specialty board certification or eligibility, nor is it to be used for changing or updating other records.

ADL	Adolescent Medicine
AI	Allergy and Immunology
AM	Aerospace Medicine
A	Allergy
AN	Anesthesiology
BE	Broncho-Esophagology
BLB	Bloodbanking
CD	Cardiovascular Diseases
CT	Computerized Tomography
D	Dermatology
DMP	Dermatopathology
DIA	Diabetes
EEG	Electroencephalography
EM	Emergency Medicine
END	Endocrinology
FP	Family Practice
GE	Gastroenterology
GP	General Practice
GPM	General Preventive Medicine
GER	Geriatrics
GYN	Gynecology
HEM	Hematology
HBM	Hyperbaric Medicine
HYP	Hypnosis
IG	Immunology
CLIG	Immunology, Clinical
ID	Infectious Diseases
INF	Infertility
IM	Internal Medicine
LAR	Laryngology
LM	Legal Medicine
MFS	Maxillofacial Surgery
ND	Neoplastic Diseases
NEP	Nephrology
N	Neurology
NPM	Neonatal-Perinatal Medicine
CHN	Neurology, Child
NA	Neuropathology
NM	Nuclear Medicine
NR	Nuclear Radiology
NTR	Nutrition
OBS	Obstetrics
OBG	Obstetrics and Gynecology
OM	Occupational Medicine
ON	Oncology
RON	Oncology, Radiation
CLON	Oncology, Clinical
ONS	Oncology, Surgical
OPH	Ophthalmology
OT	Otology
OTO	Otorhinolaryngology
OTOHN	Otolaryngology, Head and Neck
PTH	Pathology
CLP	Pathology, Clinical
FOP	Pathology, Forensic
PD	Pediatrics
PDA	Pediatrics, Allergy
PDC	Pediatrics, Cardiology
PDE	Pediatric Endocrinology
PHO	Pediatric Hematology-Oncology
PNP	Pediatric Nephrology
PHA	Pharmacology
PA	Pharmacology, Clinical
PM	Physical Medicine and Rehabilitation
PHY	Physiology
P	Psychiatry
CHP	Psychiatry, Child
PYA	Psychoanalysis
PYM	Psychosomatic Medicine
PH	Public Health
PUD	Pulmonary Diseases
R	Radiology
DR	Radiology, Diagnostic
PDR	Radiology, Pediatric
TR	Radiology, Therapeutic
RHY	Rheumatology
RHI	Rhinology
RIP	Radioisotopic Pathology
ABS	Surgery, Abdominal
CDS	Surgery, Cardiovascular
CRS	Surgery, Colon and Rectal
GS	Surgery, General
HS	Surgery, Hand
HNS	Surgery, Head and Neck
NS	Surgery, Neurological
ORS	Surgery, Orthopedic
PDS	Surgery, Pediatric
PS	Surgery, Plastic
TS	Surgery, Thoracic
TRS	Surgery, Traumatic
U	Surgery, Urological
VS	Surgery, Vascular
PVS	Surgery, Peripheral Vascular
OS	Other; *ie,* physician designated a specialty other than those appearing here
US	Unspecified
RET	Retired

To: *Wisconsin Medical Journal,* Box 1109, Madison, Wisconsin 53701

Please correct my listing in the 1980-81 Membership Directory as follows:

COUNTY MEDICAL SOCIETY _____

SPECIALTIES _____/_____/_____

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE ( ) _____

SIGNED _____ DATE _____

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GS
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ORS
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Ashland WI 54806

GS OPH
Doty, John W
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(715) 682-4515

R
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Rt 1 Box 163S
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200 7th Ave W
Ashland WI 54806

FP
Koeller, Arlyn A
206 6th Ave W
Ashland WI 54806
(715) 682-6622

GP GS
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U
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Washburn WI 54891
(715) 682-5506

U
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Rt 3 Box 36
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320 Superior Ave
Washburn WI 54891
(715) 373-2216

DR R
Lind, Robert G
2101 Beaser Ave #4
Ashland WI 54806

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Ashland WI 54806

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327 Silver St PO Box 277
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R
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AN
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OBG
Sandin, Howard N
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IM
Soucheray, Philip H
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(715) 682-5511

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Stanley, Robert A
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320 Superior Ave
Washburn WI 54891

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Ashland WI 54806
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FP
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Ashland WI 54806
(715) 682-2358

OBG
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GP
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220 Douglas St
Chetek WI 54728

ORS
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Rice Lake WI 54868

GS GP
Choudhuri, Bishnu P
707 Ash St
Spooner WI 54801
(715) 635-2151

FP
Cotts, Lloyd R
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

FP
Cragg, Michael M
1020 Lakeshore Dr
Rice Lake WI 54868

FP
Damroth, Michael S
Rt 3
Chetek WI 54728

IM
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1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

GP
Eidsmoe, Noland A
810 S Main St
Rice Lake WI 54868
(715) 234-2611

U
Eschenbaum, Edward G
1035 N Main St
Rice Lake WI 54868
(715) 234-6874

GP OBG
Flogstad, Duane L
Shell Lake WI 54871

GS
Fogarty, James P
Rt 2 Box 304-C
Chetek WI 54728

GP
Goellner, Paul G
707 Ash St
Spooner WI 54801

FP
Goetsch, Frederick H
418 Oak St
Spooner WI 54801
(715) 635-2151

GP
Halberg, Avery C
Turtle Lake WI 54889
(715) 986-2240

FP GS
Hartzell, Richard L
PO Box 169
Grantsburg WI 54840
(715) 463-5317

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Hay, Alan J
221 Bolling Dr
Goldsboro NC 27530
(919) 778-4910

FP
Henningsen, John
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

FP GS
Hoyer, John K
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

GS
Jirsa, Harold O
3409 Nottingham Rd
Ocean Springs MS 39564

FP
Kristensen, Lowell A
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

FP
Lingen, Thomas A
PO Box 127
Cumberland WI 54829
(715) 822-2231

GP
Lund, Robert E
PO Box 127
Cumberland WI 54829
(715) 822-2231

GP
Maser, James F
1020 Lakeshore Dr
Rice Lake WI 54868
(715) 234-9031

All members are MDs unless otherwise indicated.

GS RET
Matson, Kenneth L
10738 Santa Fe Dr
Sun City AZ 85351
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Number of members by county medical society

as of December 31, 1980

Ashland-Bayfield-Iron	33
Barron-Washburn-Burnett	40
Brown	183
Calumet	13
Chippewa	33
Clark	13
Columbia-Marquette-Adams	30
Crawford	3
Dane	613
Dodge	48
Door-Kewaunee	21
Douglas	23
Eau Claire-Dunn-Pepin	133
Fond du Lac	88
Forest	2
Grant	21
Green	58
Green Lake-Waushara	16
Iowa	8
Jefferson	49
Juneau	7
Kenosha	102
La Crosse	166
Langlade	12
Lincoln	20
Manitowoc	61
Marathon	127
Marinette-Florence	25
Milwaukee	1349
Monroe	15
Oconto	8
Oneida-Vilas	65
Outagamie	144
Ozaukee	29
Pierce-St Croix	4
Polk	2
Portage	5
Price-Taylor	1
Racine	14
Richland	1
Rock	11
Rusk	
Sauk	2
Sawyer	
Shawano	2
Sheboygan	9
Trempealeau-Jackson-Buffalo	1
Vernon	1
Walworth	2
Washington	5
Waukesha	23
Waupaca	2
Winnebago	16
Wood	19
No county affiliation	
Total	485

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T—Carroll M Martin, MD
407 13th St
Racine, WI 54303
ES—Mr Gilbert J Berthelsen
PO Box 592
Racine, WI 53401

RICHLAND
P—Kilian H Meyer, MD
1313 West Seminary St
Richland Center, WI 53581
S—L Maramon Pippin, MD
1313 West Seminary St
Richland Center, WI 53581

ROCK
P—Thomas M Shearer, MD
1011 N Main St
Edgerton, WI 53534
S—William S Traudt, MD
2020 E Milwaukee St
Janesville, WI 53545

RUSK
P—Ralph P Bennett, MD
906 College Ave, West
Ladysmith, WI 54848
S—Howard T Chatterton, MD
906 College Ave, West
Ladysmith, WI 54848

SAUK
P—James R Damos, MD
1900 North Dewey Ave
Reedsburg, WI 53959
S—Michael R Schonfeld, MD
1900 North Dewey Ave
Reedsburg, WI 53959

SAWYER
P—Lloyd M Baertsch, MD
Rt 6, Box 700
Hayward, WI 54843
S—Paul Strapon III, MD
Rt 6, Box 700
Hayward, WI 54843

SHAWANO
P—Richard R Stoughton, MD
117 East Green Bay St
Shawano, WI 54166
S—Alois J Sebesta, MD
126½ South Main St
PO Box 311
Shawano, WI 54166

SHEBOYGAN
P—James B Kuplic, MD
1226 N Eighth
Sheboygan, WI 53081
S—James L Weygandt, MD
Kohler Company
Kohler, WI 53044

TREMPEALEAU-JACKSON-BUFFALO
P—W Bradford Martin, MD
1933 Park St
Whitehall, WI 54773
S—James J Dickman II, MD
610 West Adams St
Black River Falls, WI 54615

VERNON
P—Phillips T Bland, MD
100 Melby St
Westby, WI 54667
S—DeVerne W Vig, MD
125 West Jefferson
Viroqua, WI 54665

WALWORTH
P—Menandro Tavera Jr, MD
Rt 4, Box 246
Lake Geneva, WI 53147
S—James V Seegers, MD
Walworth, WI 53184

WASHINGTON
P—William M Claybaugh, MD
N75 W22423 Chestnut Hill Rd
Sussex, WI 53089
S—James D Froehlich, MD
322 South 10th Ave
West Bend, WI 53095

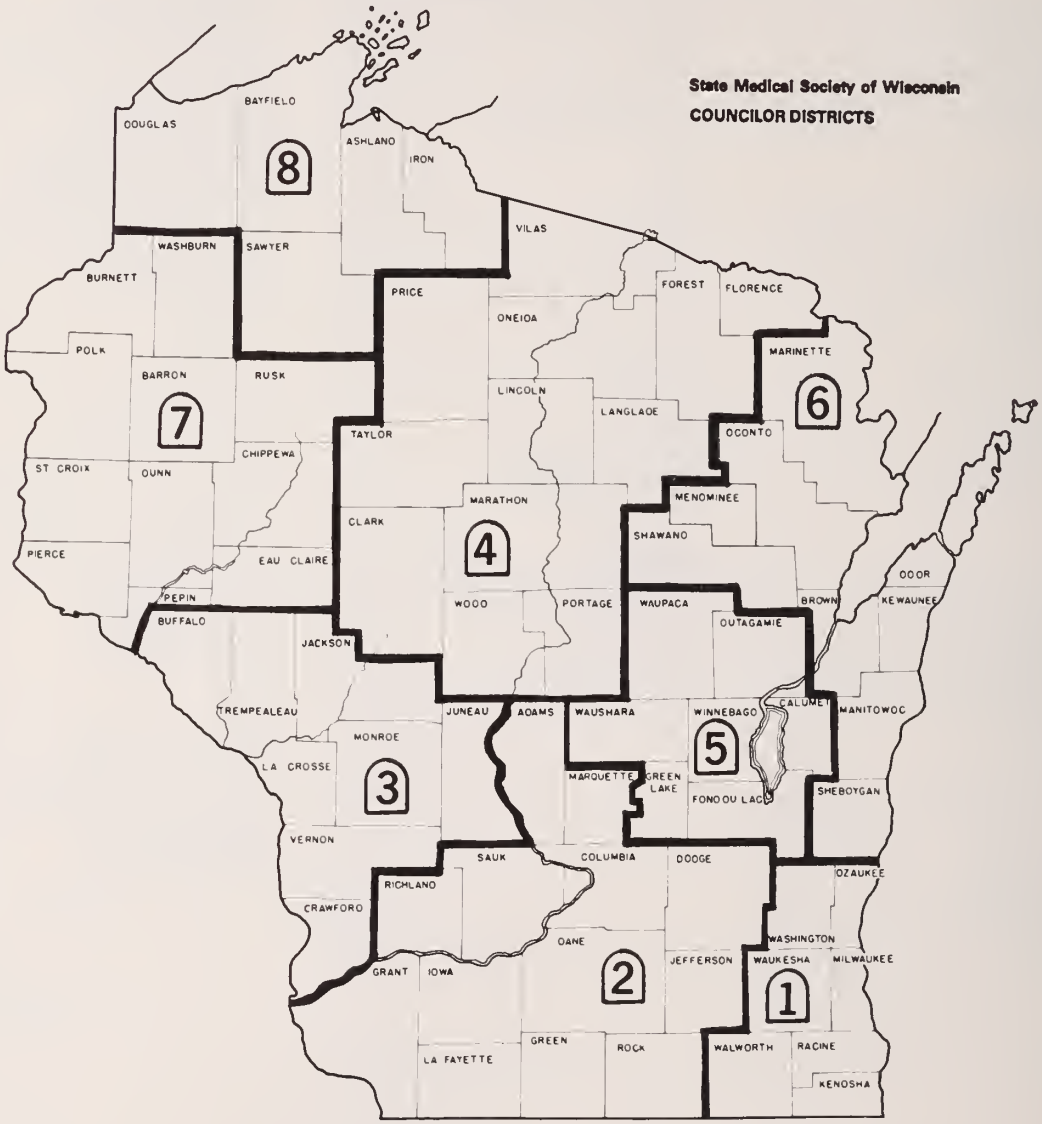
WAUKESHA
P—Lee M Tyne, MD
17050 West North Ave
Brookfield, WI 53005
S—Matthew A Meyer, MD
W290 N3159 Hillcrest
Pewaukee, WI 53072
T—Robert C Zimmerman, MD
N89 W16785 Appleton Ave
Menomonee Falls, WI 53051
ES—Mr Robert Herzog
850 Elm Grove Rd
Elm Grove, WI 53122

WAUPACA
P—D Mark Lochner, MD
PO Box 387
Waupaca, WI 54981
S—Jerry R Salan, MD
710 Riverside Dr, PO Box 387
Waupaca, WI 54981

WINNEBAGO
P—Safouh A Atassi, MD
169 East North Water St
Neenah, WI 54956
S—Roy E Buck, MD
111 E North Water St
Neenah, WI 54956

WOOD
P—Charles F Wood, MD
1221 48th Street, South
Wisconsin Rapids, WI 54494
S—Richard A Leer, MD
1000 North Oak Ave
Marshfield, WI 54449■

COUNCILOR DISTRICTS AND COUNCILORS



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1	John P Mullooly, MD, Milwaukee Paul G LaBissoniere, MD, Wauwatosa Carl S L Eisenberg, MD, Milwaukee Elizabeth A Steffen, MD, Racine Wayne J Boulanger, MD, Milwaukee John J Foley, MD, Menomonee Falls William A Nielsen, MD, West Bend Irwin J Bruhn, MD, Walworth Thomas A Hofbauer, MD, Menomonee Falls
2	J D Kabler, MD, Madison Gerald C Kempthorne, MD, Spring Green William P Crowley, MD, Madison Allen O Tuftee, MD, Beloit Cyril M Hetsko, MD, Madison
3	Pauline Jackson, MD, LaCrosse
4	John J Kief, MD, Rhinelander Jung K Park, MD, Wisconsin Rapids
5	John U Peters, MD, Fond du Lac Timothy T Flaherty, MD, Neenah
6	Roger L von Heimburg, MD, Green Bay Irvin L Schroeder, MD, Plymouth
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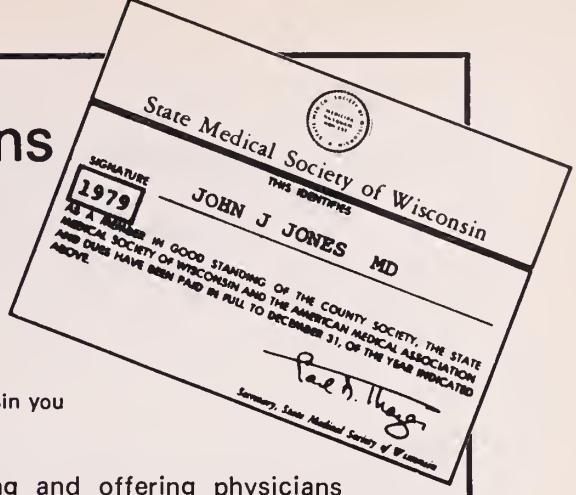

These are challenging times for any profession —times when you need the active, aggressive support of your national, state, and county medical societies to give you the professional edge you need to advance and grow. As a member of the State Medical Society of Wisconsin you receive many valuable benefits. Among them:

- **SMS Annual Meeting**—Sponsored each spring and offering physicians quality scientific and socio-economic programs, many available for CME credit.
- **Wisconsin Medical Journal and Medigram**—These publications bring you the latest in medical news affecting you and your patients.
- **Wisconsin Physicians Planning Network**—Is working to assure physician representation in the health planning process and new health services systems.
- **An Organized Lobbying Effort**—Working in Madison to ensure Wisconsin physicians have a voice in healthcare problems and issues presented to the Wisconsin Legislature.
- **An Aggressive Socioeconomic Program**—The Physicians Alliance Division deals with the Medicare/Medicaid programs of government, monitors and comments on activities of third-party carriers of health insurance, and conducts efforts to inform the public of the costs and constraints of the healthcare delivery system.
- **Mediation and Peer Review**—Physicians, through a special commission, are "policing the profession" by mediating complaints of the public against physicians and where necessary imposing discipline.
- **Impaired Physician Program**—Was recently formed to help the impaired physician—the doctor suffering in some degree from alcoholism, other drug dependency, or mental illness.
- **Member Benefit Plans**—The Society offers comprehensive life, health and liability insurance plans for physicians and their families at attractive group rates. In addition, physicians can receive practice management tips at seminars sponsored by the Society and take advantage of car rental and travel programs at special low, "member" rates.
- **Grassroots Political Action**—Developed through the SMS Physicians Alliance, local physicians meet with their legislative representatives on a regular basis to discuss issues of importance to medicine.
- **Community Health**—Society physicians are working with community organizations and individuals in providing consumer health education programs to promote a healthier Wisconsin citizenry.
- **CESF**—The Society's Charitable, Educational and Scientific Foundation, through its physician members, administers a student loan program to help students prepare for careers in healthcare; sponsors postgraduate teaching programs for physicians; owns and operates the Museum of Medical Progress in Prairie du Chien; and for the past two years, has participated in a Jail Health Care Accreditation Program of the American Medical Association.
- **Uniform Claim Form**—These forms, developed by the Society working with local insurance carriers, can be used by physicians in submitting claims to all private insurance companies in Wisconsin, Medicare, and Medicaid.

Membership Report

This listing appears as a newsworthy feature and is not intended to reflect the total membership report. Members wishing the full report may request it from the Membership Department.

Membership report as of November 14, 1980

NEW MEMBERS

County Medical Society

CALUMET

Pleviak, Denis J, 2301 Mary, New Holstein (1951, Regular, Family Physician)

Theiler, Randy T, 451 E Brooklyn St, Chilton 53014 (1950, Regular, Family Physician)

CHIPPEWA

Harrison, Les, 2501 County Trunk I, Chippewa Falls 54729 (1950, Regular, Internal Medicine)

Paulson, Steven G, 2501 County Trunk I, Chippewa Falls 54729 (1951, Regular, Internal Medicine)

Proett, A Frederick, 345 Prairie View Rd, Chippewa Falls 54729 (1947, Regular, Orthopedic Surgeon)

CLARK

Hopkins, William P, Owen 54460 (1950, Regular, Family Physician)

COLUMBIA-MARQUETTE-ADAMS

Slavik, Paul J, 916 Silver Lake Dr, Portage 53901 (1948, Regular, Internal Medicine, Certified)

DANE

Davis, Jeffrey D, 30 South Henry St, Madison 53703 (1947, Regular, Gastroenterology/Internal Medicine, Certified-IM)

Loevinger, Barbara L, 5002 Sheboygan Ave, #209, Madison 53705 (1950, Resident, Psychiatry)

DOUGLAS

Berry, Douglas G, 825 Rockview Ct, Duluth, MN 55804 (1939, Regular, Anesthesiology/Clinical Pharmacology, Certified-AN)

EAU CLAIRE-DUNN-PEPIN

Haumschild, Ronald L, 1030 Oakridge Dr, Eau Claire 54701 (1948, Regular, General Surgery)

Wilson, Louis J, 807 South Farwell, PO Box 1123, Eau Claire 54701 (1923, Regular, Family Physician/Hypnosis, Certified-FP)

Woodhouse, Charles L, 733 W Clairemont Ave, Eau Claire 54702 (1949, Regular, Oncology/Internal Medicine, Certified-IM)

GREEN LAKE-WAUSHARA

Taber, Alan L, 261 Memorial Dr, Berlin 54923 (1951, Regular, Family Physician)

Halac, Mehmet E, PO Box 336, Redgranite 54970 (1932, Regular, Internal Medicine, Certified)

JEFFERSON

Anschuetz, Harold F, 211 Memorial Dr, Fort Atkinson 53538 (1945, Regular, Family Physician)

Chin, Moe L, 1507 Doctors Court, Watertown 53094 (1951, Regular, Family Physician)

Williams, Donald L, 500 McMillen St, Fort Atkinson 53538 (1951, Regular, Internal Medicine/Pediatrics)

MARATHON

Burwitz, James E, 801 Gilbert St, Wausau 54401 (1952, Resident, Family Physician)

Campbell, Daniel B, 801 Gilbert St, Wausau 54401 (1951, Resident, Family Physician)

Edwards, M Thomas, 2727 Plaza Dr, Wausau 54401 (1950, Regular, Pediatrics)

Larson, David L, 1100 Lake View Dr, Wausau 54401 (1941, Regular, Psychiatry, Certified-PN)

Luthra, Vinay D, 604 Sturgeon Eddy Rd, Wausau 54401 (1951, Regular, Diagnostic Radiology/Radiology, Certified-R)

Owen, William R, 2727 Plaza Drive, Wausau 54401 (1946, Regular, Dermatology, Certified)

Russ, Brigitte S, 1100 Lake View Dr, Wausau 54401 (1918, Regular, Psychiatry/Dermatology)

Tanner, George R, 2727 Plaza Dr, Wausau 54401 (1945, Regular, Orthopedic Surgeon, Certified)

MILWAUKEE

Benzel, Edward C, 8700 W Wisconsin Ave, Milwaukee 53226 (1948, Regular, Neurological Surgery)

Briselli, Michael F, 2900 W Oklahoma Ave, Milwaukee 53215 (1949, Regular, Pathology, Certified)

Fox, Martin J, 7037 St James St, Wauwatosa 53213 (1952, Resident, Ophthalmology)

Girolami, James F, 610 North 19th St, Milwaukee 53233 (1951 Regular, Family Physician)

Hoogerland, David L, 2320 North Lake Dr, Milwaukee 53211 (1944, Regular, Obstetrics and Gynecology, Certified)

Keay, Timothy J, 620 North 19th St, Milwaukee 53233 (1953, Resident, Family Physician)

Klamer, Thomas W, 950 North 12th St, Milwaukee 53233 (1950, Regular, General Surgery, Certified)

Malinowski, Rodney W, 821 North 117th St, Wauwatosa 53226 (1949, Resident, Plastic Surgery/General Surgery)

Poremski, Tod J, 2500 N Mayfair Rd, Wauwatosa 53226 (1950, Regular, Obstetrics and Gynecology)

Suberviola, P Daniel, 3070 North 51st St, Milwaukee 53210 (1945, Regular, Neurological Surgery, Certified)

Tiber, Charles H I, 2388 North Lake Dr, Milwaukee 53211 (1952, Regular, Internal Medicine/Oncology, Certified-IM)

ONEIDA-VILAS

Boismenue, Stuart N, 1020 Kabel Ave, Rhinelander 54501 (1946, Regular, Pediatrics)

PIERCE-ST CROIX

Stoy, Robert J, 220 Vine St, Hudson 54016 (1951, Regular, Family Physician, Certified)

RACINE

Tiffany II, Joseph C, 3803 Spring St, Racine 53405 (1939, Regular, General Surgery, Certified)

SHEBOYGAN

Campbell, Richard L, 721 Oak Tree Rd, Sheboygan 53081 (1950, Regular, Diagnostic Radiology, Certified-R)

Haas, Richard A, 4517 Pheasant Lane, Sheboygan 53081 (1943, Regular, Anesthesiology/Emergency Medicine)

Lalich (DO), Roger, 712 Ramdom Lake Rd, Random Lake 53075 (1948, Regular, Family Physician)

Zweifel (DO), Thomas J, 1720 N 8th St, Sheboygan 53081 (1947, Regular, Neurology)

WINNEBAGO
Haffer, Ahmad Y, 2023 North Point, Oshkosh 54901 (1947, Regular, Neurology, Certified-P & N)

CHANGE OF ADDRESS

(Does not include those within the city)

COLUMBIA-MARQUETTE-ADAMS
Broderick, Clifford F, Sun City, AZ, to 211 Hearthstone Reach, Peachtree City, GA 30269

DANE
Reinholtz, Paul E, Madison, to 2600 E Southern Ave, Tempe, AZ 85282

LANGLADE
Dailey, Dee William, Elcho, to 16813 102nd Ave, Sun City, AZ 85351

MILWAUKEE
Moede, James G, Milwaukee, to Rte #3, Fond du Lac 54935
Watson, Raymond R, Mequon, to 14 Berkeley Place, Huntington, WV 25705

WOOD
Malik, Saleem A, Marshfield, to Henry Ford Hospital, 2799 W Grand Blvd, Detroit, MI 48202

COUNTY-TO-COUNTY TRANSFER

Dane to Milwaukee: Durkee, Charles T, 3385 Cardinal Dr, Brookfield 53005
Fond du Lac to Milwaukee: Moede, James G, Rte #3, Fond du Lac 54935
Waukesha to Washington: Friedman, Robert H, N89 W16840 Appleton Ave, Menomonee Falls 53051

DEATHS

Ovitz, Ernest G, Forest County, Sept 11, 1980
Finn, Milton, Douglas County, Oct 30, 1980
Carey, Harold W, Grant County, Nov 16, 1980 ■

Membership report as of December 15, 1980

NEW MEMBERS

County Medical Society

BARRON-WASHBURN-BURNETT
Schipitsch, Douglas A, 1475 Webb St, Cumberland 54829 (1950, Regular, General Surgery, Certified)

FOND DU LAC
Agnelneri Jr, Mauro J, 80 Sheboygan St, Fond du Lac 54935 (1950, Regular, Urology)
Masunuru, Jagadeesware Rao, 459 East 1st St, Fond du Lac 54935 (1945, Regular, Psychiatry)

LACROSSE
Doescher, Philip O, 1836 South Ave, LaCrosse 54601 (1946, Regular, Therapeutic Radiology/Radiology, Certified-R)
Fox, Richard E, 1836 South Ave, LaCrosse 54601 (1953, Resident, General Surgery)
Gabster, Alan A, 1836 South Ave, LaCrosse 54601 (1948, Regular, Cardiovascular Diseases/Internal Medicine, Certified-IM)
Wiersma, Rustan J, 815 S 10th St, LaCrosse 54601 (1950, Regular, Otorhinolaryngology)

LINCOLN
Evans, Donald L, 1205 O'Day St, Merrill 54452 (1951, Regular, Family Physician, Certified)
Reding, Rick R, 404 South 3rd Ave, Wausau 54401 (1951, Regular, Internal Medicine)

MILWAUKEE
DeQuina, Magtangol R, 4819 S Packard Ave, Cudahy 53110 (1939, Regular, Family Physician, Certified)

MONROE
Burnett, David E, 315 West Oak St, Sparta 54656 (1952, Regular, Family Physician, Certified)

OCONTO
Heinzl, Glen J, 1007 Pecor St, Oconto 54153 (1951, Regular, Family Physician)

OUTAGAMIE
Boren Jr, Clark H, 900 East Grant St, Appleton 54911 (1947, Regular, General Surgery/Cardiovascular Surgery, Certified-GS)
Smith, Franklin A, 4321 N Ballard Rd, Appleton 54911 (1934, Regular, Internal Medicine, Certified-IM)

RACINE
Anderson, Clifford, 226 Wolff St, Racine 53402 (1917, Regular, Dermatology/Public Health)
Klein, Kenneth A, 2900 W Oklahoma Ave, Milwaukee 53215 (1943, Regular, Therapeutic Radiology, Certified-R)
Miller Jr, Donald W, 2405 Northwestern Ave, Racine 53404 (1951, Regular, Obstetrics and Gynecology)
Shanahan, Michael B, 5625 Washington Ave, Racine 53406 (1950, Regular, Internal Medicine)
Udesky, Richard H, 3801 Spring St, Racine 53405 (1949, Regular, Diagnostic Radiology/Radiology, Certified-R)

CHANGE OF ADDRESS

(Does not include those within the city)

DANE
Hill, Nels A, Madison, to 4502 N Federal Highway, Lighthouse Point, FL 33064
Juhl, John H, Oregon, to 2617 Cutler Northeast, Albuquerque, NM 87196

GREEN
Nemovitz, Paul M, Monroe to, 10 Springwood Circle, Madison 53717

KENOSHA
Kappus, Harold C, Kenosha, to 4703 Brisa Del Norte, Tucson, AZ 85718

MILWAUKEE
Holbrook, Arthur A, Milwaukee, to 1633 Boathouse Circle, Sarasota, FL 33581
Schutte, Albert G, Mukwonago, to 6689 Van Gordon Court, Arvada, CO 80004

OUTAGAMIE
Todd, Jean, Appleton to, 411 10th St SE, Cedar Rapids, IA 52403

PRICE-TAYLOR
Schoenfeld, Paul M, Phillips, to 10943 S Harding Ave, Chicago, IL 60655

WINNEBAGO
Schwab, Robert L, Neenah, to Rte 11 Holland Dr, Fayetteville, AR 72701

COUNTY-TO-COUNTY TRANSFER

Chippewa to Sauk: Henry, Richard A, 2000 N Dewey St, Reedsburg 53959
Columbia-Marquette-Adams to Dodge: Hansell, Charles E, 410 S Lewis St, Columbus 53925
Dane to Jefferson: Holden, Richard C, 123 Hospital Dr, Watertown 53094

Dane to Dodge: Tu, Her-Lang, 724 Tulip Lane, Waupun 53963
Lincoln to Brown: Sanan, Omer K, 621 E Walnut St, Green Bay 54302

DEATHS

Flynn, Robert E, LaCrosse County, Oct 29, 1980
Korns, Michael E, Milwaukee County, Nov 19, 1980
Charles, John D, Milwaukee County, Dec 5, 1980 ■

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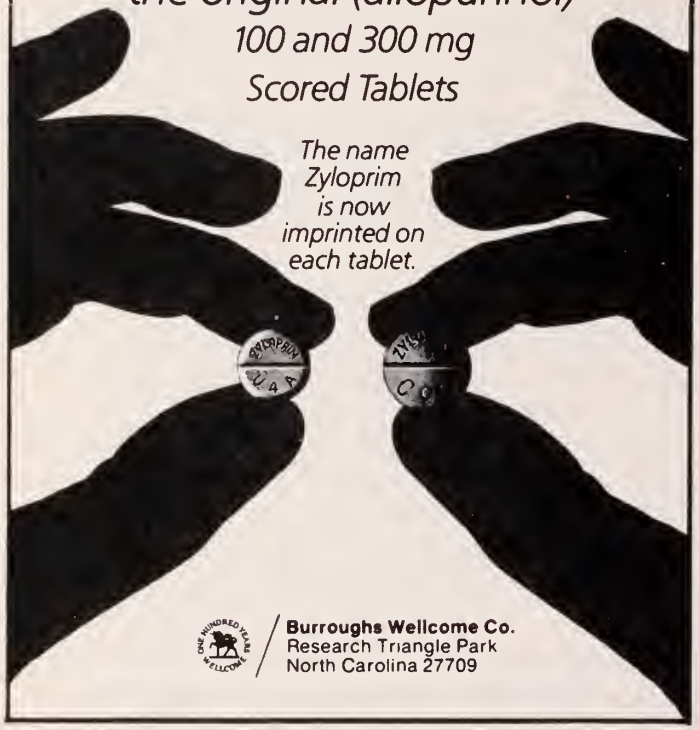

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raindications: Glaucoma, prostatic hyper- benign bladder neck obstruction, hyper- tivity to chlordiazepoxide HCl and/or um Bromide

ings: Caution patients about possible com- effects with alcohol and other CNS ssants, and against hazardous occupations ing complete mental alertness (e.g., operat- achinery, driving). Physical and psychologi- pendence rarely reported on recommended , but use caution in administering Librium® diazepoxide HCl/Roche) to known addic tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered, isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis); jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, potential for being abused Psychic dependence, physical dependence, and tolerance may develop upon repeated adm tion of this drug and it should be prescribed and administered with the same degree of caution appropriate to the us oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Fed trolled Substances Act

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities require performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this dru be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) tantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contempl dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal deve Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the benefits outweigh the possible hazards

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their ca elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may ob clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the dia clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies patients w polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, sedation, nausea and vomiting These effects seem to be more prominent in ambulatory than in nonambulatory pat some of these adverse reactions may be alleviated if the patient lies down Other adverse reactions include dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion ness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding wit Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be mani a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated ad tion of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the respon patient It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally adult dose for Empirin with Codeine No 2 and No. 3 is one or two tablets every four hours as required. The usual for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

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Board certified or Eligible primary care internist and family practitioners for full-time positions in medical school and teaching hospital affiliated community ambulatory care centers. Appointees eligible for faculty appointments. Wisconsin licensure required. Positions available July 1981. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 West Wisconsin Ave, Milwaukee, Wis 53233. Equal Opportunity Employer M/F/H. 1-4/81

Board eligible or Board certified psychiatrist to join group of 49 medical specialists. To work with another psychiatrist, psychologist, and a clinical social worker in both outpatient and hospital environment. The Department covers a broad-based psychiatric practice. Quality medicine close to University Centers. Competitive income. Contact R E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566, or telephone collect 608/328-7000. 1-3/81

Dermatologist desires partnership, group association or solo location in Wisconsin or Minnesota. Board certified. Experienced surgery, PUVA and x-ray therapy. Contact Dept 485 in care of the Journal. p11-12/80,1/81

Wisconsin locum tenens available. Family practice, can do OB and ER. High productivity. Write: Locum Tenens, 5695 Merry Lane, Excelsior, Minn 55331. Phone: 612/474-4372. p11-12/80,1-2/81

The Nicolet Clinic, SC, a young progressive 33 physician multispecialty group, has superb opportunities available for the practice of:

- Nephrology
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- Family Practice
- Radiology

Ideal family oriented community in metropolitan area with excellent schools, economy, culture, and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued medical education. Contact in confidence Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Phone: 414/727-4244. 11-12/80,1-2/81

Relocation opportunities or initial practice in Fox Valley for general internists, family practitioners, and pediatricians. Support of other independent practitioners assured. Excellent schools, recreational area, as well as clinical facilities in JCAH approved hospital. PO Box 801, Neenah, Wis 54956. p11-12/80,1-4/81

Family Practice. General Clinic — Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Grow with us in sunny Arizona. The INA Healthplan needs physicians in family practice and most specialties in Tucson and Phoenix. Competitive salaries and comprehensive benefits including a professional development program, retirement plan, and group incentive bonus are provided. If team interaction and casual living interest you, send your CV to: Professional Relations, INA Healthplan, Inc, 6115 North 7th St, Phoenix, AZ 85014. 12/80, 1-2/81

OBSTETRICIANS-GYNECOLOGISTS WANTED

Obstetricians-Gynecologists board certified or eligible wanted to join in practice with obstetrician-gynecologist in a city of 100,000 on Lake Michigan between Milwaukee and Chicago. Excellent schools, medical school affiliation, security of freedom of practice in independent small group. Contact: Elizabeth A Steffen, MD, 734 Lake Ave, Racine, Wis 53404. Phone: 414/637-8311. 6tfn/80

Physicians Exchange

continued

Emergency Physician. Wausau, Wisconsin. Residency training and/or ER experience required. Fee for service corporation with excellent income and benefits. New facility with excellent backup. Family and sportsman's paradise. Send CV or call: Fred A Klemm, MD, 2404 Hawthorne Lane, Wausau, Wis 54401. Phone: 715/842-9373. p11-12/80,1/81

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 20-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 7tfn/80

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

General Surgeon and Orthopedic Surgeon. Both needed for 7-man multispecialty group in town of 10,000. Located 30 miles southwest of Milwaukee. Our facility is immediately adjacent to a 140-bed hospital. Position open immediately. Please contact Wayne Hansen, Burlington Medical Center Ltd, 190 Gardner Ave, Burlington, Wis 53105. 414/763-9121. p12/80,1/81

Family Practice. Wanted a family practitioner to locate in new clinic building in Poynette, Wis. Located 30 miles from Madison, Wis. Poynette is a village of approximately 1000 with a service area of 7000 persons. Salary guaranteed. Contact John Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 10tfn/80

Racine Medical Clinic, SC, multispecialty group of 20 physicians has a practice association for:

- General Surgeon

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 9tfn/80

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Licensed Employment Agency 9tfn/79

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS. Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Cardiology
- Family Practice
- Hematology/Oncology
- Otolaryngology

Beautiful new building adajacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Orthopedic surgeon wanted to join a primary care/specialty group of 11 physicians in northwestern Wisconsin. Attractive family/recreational area 45 minutes from Twin Cities. Minimum salary guaranteed first year. Contact Tom Halverson, Clinic Manager, St Croix Falls Clinic, Box 739, St Croix Falls, Wis 54024. Phone 715/483-3221. 8tfn/80

Cardiologist or internist with an interest in cardiology for Twin Cities Internists Group. CCU, EKG lab, and resident teaching responsibilities. Cath lab available. Position requires necessity to deliver some general medical care. Curriculum vitae and references mailed to Dept 486 in care of the Journal. 12/80, 1-2/81

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multi-specialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

PRIMARY CARE PHYSICIANS
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We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

8-12/80,1-7/81

Family Practitioner to join three-man group. Senior partner retiring. Community of 3500 on Interstate-94 between Madison and Milwaukee on Rock Lake, one of the finest lakes in Wisconsin. Salary and fringe benefits first year. Contact H Leering, MD, Lake Mills, Wis 53551. Tel: 414/648-2391. 6tfn/78

Physician wanted to perform light physicals five days per week in the Milwaukee area. Ideal job for retiring physician. Contact Mike Stough, collect, at 513/621-8728. 11tfn/80

Immediate opening for general and child psychiatrist to join well established clinic in a community of 50,000. Large referral area. Two excellent hospitals. University and industrial area. Salary open. Excellent benefits. Contact: J M Tobin, MD, Northwest Psychiatric Clinic, Box 224, Eau Claire, Wis 54701. Phone: 715/834-2751. 12/80, 1-2/81

Full Time Faculty Position—Assistant Director of the sixth and newest Family Practice Residency Program of The Medical College of Wisconsin. Potential to become associate director, dependent upon qualifications. Faculty appointment to the highly successful Department of Family Practice of The Medical College of Wisconsin. Opportunity to participate in the formulation of a new program; residents to begin training July, 1981. Outstanding Family Practice Center facilities. Candidate must be Board certified or Board eligible in Family Practice. Located in Southeastern corner of Wisconsin; 45 minutes from Milwaukee; 60 minutes from Chicago. Faculty rank and salary are negotiable, dependent upon qualifications and experience. Many fringe benefits. Send curriculum vitae and references to: R G Burnett, MD, Program Director, Southeast Family Practice Residency Program of the Medical College of Wisconsin, Tallent Hall, University of Wisconsin-Parkside, PO Box 598, Kenosha, Wis 53141. The Medical College of Wisconsin is an Equal Opportunity/Affirmative Action Employer. 12/80;1/81

Wanted. Board certified or eligible oncologist to practice in conjunction with an 8-member medical department in a 22-member multispecialty group. Present sub-specialties: gastroenterology and cardiology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Pediatrician: Join an 18 physician multispecialty clinic in Appleton, Wisconsin. Have departments in Pediatrics, Surgery, Family Practice, Internal Medicine and OB/GYN. Need another pediatrician. Excellent hospitals, guarantee and incentive compensation. Complete benefit package. Medium size community with excellent educational, cultural, recreational, and shopping opportunities. Contact Art Schuetze, Medical Arts Clinics, SC, 401 North Oneida St, Appleton, Wis 54911. Telephone 414/739-0171. 1-3/81

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Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

For Sale: Zeiss Photomicroscope with circular rotating and centering mechanical stage, automatic exposure device and full power pack. Several objective and ocular lenses. Excellent condition. Regularly maintained by manufacturer's representative. Contact Mr. Bernard Goldstein, 606 West Wisconsin Ave, Milwaukee, Wis 53203. Phone: 414/271-1400. g10tfn/80

FOR RENT office space Greater Milwaukee area. 750-1500 sq ft in prestigious 3-year-old medical building located on Northridge Lakes (7400 West Brown Deer Road) only minutes from Northridge. Opportunity for medical group, specialist, or satellite office. Will remodel to suit. Please call area code 414/354-1160. 12tfn/80

For Sale. Dictaphone, think tank and transcriber—excellent condition. Phone: 414/457-4438. 1tfn/81

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NEW PHYSICIANS FOR WISCONSIN

AND THE UNIVERSITY OF WISCONSIN-MADISON

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NEW PHYSICIANS FOR WISCONSIN IS PARTIALLY FUNDED BY THE STATE OF WISCONSIN

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of poblication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1980 through Aug 31, 1981.

WISCONSIN

FEBRUARY 10-12, 1981: The 18th Annual Telemark Symposium and Ski Outing, Mt Telemark, Cable, Wis. Presented by the Indianhead Chapter of the Wisconsin Academy of Family Physicians. Faculty from the Mayo Clinic. Six hours credit Category I of the AMA-PRA and AAFP. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

FEBRUARY 18-21, 1981: Society of Teachers of Family Medicine Midwest Regional Research Skills Workshop, Good Samaritan Medical Center, Milwaukee. Approved 21/AAFP prescribed credit hours. Info: Jane Barclay Mandel, PhD, The Medical College of Wisconsin, Dept of Family Practice, Seton Tower, 2315 North Lake Dr, Milwaukee, Wis 53211. Phone: 414/291-0813.

FEBRUARY 23, 1981: Special Endoscopic Demonstration Program for Physicians at Digestive Disease Center of St Luke's Hospital, Racine. Presented by the Section of Gastroenterology, The Medical College of Wisconsin and St Luke's Hospital, Racine. Info: Joseph E Geenen, MD, GI Section, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. Phone: 414/291-0813.

FEBRUARY 24-27, 1981: 8th Annual Endoscopy Conference *"Endoscopic Profile 1981: Assessment of Endoscopic Skills, Diagnostic Acumen and Clinical Judgment"*, Pfister Hotel, Milwaukee. Approved for 23 credit hours of Category I of AMA and 23 elective hours of AAFP. Fee: $300. Info: Joseph E Geenen, MD; Walter J Hogan, MD; GI Section, 8700 West Wisconsin Ave, Milwaukee 53226. Phone: 414/291-0813.

FEBRUARY 26, 1981: *Endoscopic Accessories*, Pfister Hotel, Milwaukee. Fee: $125. Info: Ms Marcia Pfeifer, RN, Course Director, Gastroenterology Consultants, Ltd, 1333 College Ave, Racine 53403.

MARCH 1-2, 1981: *5th Annual Winter Pediatric Seminar*, Caribou Lodge, Powderhorn Ski Area, Bessemer, Mich. Approved for 8 credit hours of Category I of the AMA-PRA and AAFP. Fee: $55. Info: Marshfield Clinic, Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449.

MARCH 19-20, 1981: *5th Annual Ophthalmology Current Concepts Seminar '81*, Sheraton Hotel, Madison. AMA Category 1 on an hour-by-hour basis. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

APRIL 9-11, 1981: *Coronary Heart Disease 1981*, Hyatt Regency Milwaukee, Wis. Presented by St Luke's Hospital and St Luke's Hospital Foundation, Inc. Fee: $250. Approved 16 credit hours of Category I of PRA-AMA and AAFP. Info: Mrs Dorothy Black, Public Relations Dept, St Luke's Hospital, 2900 W Oklahoma Ave, Milwaukee, Wis 53215.

APRIL 24, 1981: *Perspectives in Diabetes Mellitus—1981*, Madison. Approved 7 credit hours AMA and LCCME Category 1, Family Practice credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

Section of Gastroenterology, The Medical College of Wisconsin

A SPECIAL ENDOSCOPIC DEMONSTRATION PROGRAM FOR PHYSICIANS

February 23, 1981, at Digestive Disease Center of St Luke's Hospital, Racine

"LIVE" closed-circuit television demonstration of colonscopic ERCP and Endoscopic sphincterotomy procedures by world renowned Endoscopic Teachers.

ERCP and Endoscopic Sphincterotomy by ***Jack Vennes, MD*** and ***Lazlo Safrany, MD;*** Cononoscopy by ***Jerome Waye, MD*** and ***Robin Teague, MD***

Registration fee: $150. Registration will be strictly limited. Preference will be given to those physicians already registered for the 8th Annual Medical College of Wisconsin Endoscopy Conference, scheduled February 24-27, 1981, in Milwaukee.

Info: Joseph E Geenen, MD; Walter J Hogan, MD, GI Section, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. Phone: 414/291-0813.

MAY 4-6, 1981: *Intravenous-Arteriography.* University of Wisconsin-Madison, Memorial Union, Madison. Approved 16 credit hours Category I and 16 hours American College of Radiology. Fee: $395. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706. Phone: 608/263-2856.

MAY 6-8, 1981: *New Dimensions in Cardiac Rehabilitation* at Red Carpet Inn adjacent to the Milwaukee airport. Info: Department of Continuing Medical Education, University of Wisconsin, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2850.

JUNE 4-6, 1981: *Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias,* The Performing Arts, Milwaukee. Approved 18 credit hours of Category I of PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

JUNE 25-27, 1981: Annual Meeting of the Wisconsin Academy of Family Physicians, Hyatt Regency Hotel, Milwaukee. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

UPPER MIDWEST

MARCH 2-6, 1981: Seventieth Annual Meeting of the United States-Canadian Division of the International Academy of Pathology, at the Palmer House, Chicago, Illinois. The Maude Abbott Lecture entitled "The Impact on Time on the Diagnosis and Treatment of Cancer: 1936-1981," will be deology," with Dr Robert T McCluskey as course director. The long course will be on "The Inflammatory Process and Infec- livered by Dr Lauren V Ackerman on March 3. Scientific papers, poster sessions, twelve specialty conferences, and 50 short courses are scheduled. A special course will be offered on "Immunopathologic Techniques in Diagnostic Pathtious Disease," with Doctors Guido Majno and Ramzi Cotran, course directors. Further info: Dr Nathan Kaufman, Secretary-Treasurer, United States-Canadian Division of the IAP, 1003 Chafee Avenue, Augusta, Ga 30904; telephone: 404/724-2973. g7-12/80

MARCH 13-14, 1981 (Illinois): *Practice Management of Common Geriatric Problems,* Rush-Presbyterian-St Luke's Medical Center, Chicago, Ill. Approved 14 credit hours of AMA and LCCME Category I. Info: Maria Gonzales, Office of Continuing Education, Rush-Presbyterian-St Luke's Medical Center, 600 South Paulina St, Chicago, Ill 60612. Phone 312/942-7095. 1-3/81

MARCH 20-21, 1981 (NEBRASKA): American College of Physicians Meeting, Omaha. Info: Bowen E Taylor, MD, Box 81009, Lincoln, NE 68501.

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SERVING SOUTHERN-CENTRAL WISCONSIN

APRIL 6-9, 1981 (MISSOURI): 62nd American College of Physicians Annual Session, Kansas City. Info: Robert H Moser, MD, FACP, Executive Vice President, 4200 Pine St, Philadelphia PA 19104.

APRIL 30-31, 1981 (NORTH DAKOTA): American College of Physicians Meeting, Jamestown. Info: Harold W Evans, MD, 2624 Olson Drive, Grand Forks, ND 58201.

APRIL 30-MAY 2, 1981 (North Dakota): Annual Meeting, North Dakota Medical Association, at Jamestown. Info: V E Wagner, Exec Sec, PO Box 1198, Bismarck, ND 58501.

APRIL 30-MAY 5, 1981 (Kansas): Annual Meeting, Kansas Medical Society, at Salina. Info: J Slaughter, Exec Dir, 1300 Topeka Ave, Topeka, KS 66612.

MAY 1-2, 1981 (IOWA): American College of Physicians Meeting, University of Iowa, Iowa City. Info: William B Galbraith, MD, 115 Eighth St NE, Cedar Rapids, IA 52401.

MAY 3-6, 1981 (Nebraska): Annual Meeting, Nebraska Medical Association, at Lincoln. Info: K E Neff, Exec Dir, 1512 First National Bank Bldg, Lincoln, NE 68508.

MAY 20-22, 1981 (Minnesota): Annual Meeting, Minnesota State Medical Association, at Minneapolis. Info: H W Brunn, Exec Vice-pres, 2221 University Ave SE, Suite 400, Minneapolis, MN 55414.

OTHERS

FEBRUARY 27-MARCH 5, 1981 (California): 16th Annual Clinical Conference sponsored by the Medical College of Wisconsin and the Marquette-MCW Medical Alumni Association, Rancho Las Palmas Resort, Palm Springs, Calif. Info: Marquette-MCW Medical Alumni Association, 8701 Watertown Plank, Rd, Milwaukee, Wis 53226.

SOCIETY OF TEACHERS OF FAMILY MEDICINE

MIDWEST REGIONAL RESEARCH SKILLS WORKSHOP

Sponsored by The Department of Family Practice, The Medical College of Wisconsin

February 18-21, 1981, Good Samaritan Medical Center, Milwaukee, Wisconsin

This two and one-half day workshop is designed to provide faculty members within Family Medicine and other clinical specialties a background in fundamental strategies of research. The format of the workshop is brief presentations by STFM guest faculty followed by individual and small group work sessions. Areas to be covered include: formulating research questions, creating research design, synthesizing relevant literature, critiquing research proposals, identifying and utilizing resources, anticipating results, collecting data, and understanding statistics.

Fee: $300. Approved for 21 AAFP prescribed credit hours.

Info: Jane Barclay Mandel, PhD, The Medical College of Wisconsin, Department of Family Practice, Seton Tower, 2315 North Lake Dr, Milwaukee, Wis 53211. Phone: 414/291-0813.

MARCH 9-13, 1981 (California): 19th National Conference on Breast Cancer, Hotel Del Coronado, San Diego, Calif. Approved for 33 credit hours of Category I of AMA-PRA. Info: American College of Radiology, 6900 Wisconsin Ave, Chevy Chase, Maryland 20015. pI/81

APRIL 4-8, 1981 (Washington, DC): Thirty-seventh Annual Congress of the American College of Allergists, at the Sheraton-Washington Hotel, Washington, DC. Credit for Category I, Continuing Medical Education, for the AMA's Physician's Recognition Award will be granted on an hour-for-hour basis. No registration fee for fellows or residents in allergy training, or for nurses in allergy programs presenting letters from department heads of teaching hospitals. Info: Shirley Schoenberger, Exec Secy, American College of Allergists, 2141 Fourteenth St, Boulder, CO 80302; (303) 447-8111.

APRIL 21-23, 1981 (Washington, DC): *Technology Assessment Forum on Coronary Artery Bypass Surgery: Economic, Ethical, and Social Issues,* sponsored by the National Center for Health Care Technology in collaboration with National Heart, Lung and Blood Institute, National Institutes of Health, at Sheraton Washington Hotel, Washington, DC. Info: Michael Eliastam, MD, Special Assistant to the Director, National Center for Health Care Technology, Parklawn Bldg, Room 17A-29, 5600 Fishers Lane, Rockville, Md 20857; (301)443-4097.

MAY 16-20, 1981 (Ohio): Annual Meeting, Ohio State Medical Association, at Cleveland. Info: H F Page, Exec Dir, 600 S High St, Columbus, OH 43215.

JULY 30-AUGUST 2, 1981 (Ohio): *International Doctors in Alcoholics Anonymous, Annual Meeting.* Hotel reservations directly at Cleveland Marriott Inn/Beachwood, 3663 Park East Drive, Beachwood, OH 44122 or call 216/464-5950 or 800/228-9290. (Be sure to specify IDAA for special rates). Further information contact Secretary IDAA, 1950 Volney Rd, Youngstown, Ohio 44511. Phone: 216/782-6216.

AMA—1981

FEBRUARY 12-15: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 7-11: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 6-9: Interim AMA House of Delegates, Las Vegas Hilton, Las Vegas, Nev.

AMA—1982

FEBRUARY 25-28: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8: Interim AMA House of Delegates, Fountainbleu Hilton, Miami, Fla. ■

Section of Gastroenterology, The Medical College of Wisconsin

8TH ANNUAL ENDOSCOPY CONFERENCE "ENDOSCOPIC PROFILE 1981: ASSESSMENT OF ENDOSCOPIC SKILLS, DIAGNOSTIC ACUMEN AND CLINICAL JUDGMENT"

February 24-27, 1981, Pfister Hotel, Milwaukee, Wisconsin

The three-day conference features formal lectures, mini-group demonstrations, panel discussions, TV and motion pictures and exhibits. For the first time, our participants will test their clinical and diagnostic skills, in solving our renowned "teaching cases."

Guest Faculty: *H Worth Boyce, MD,* Tampa, Fla; *Thomas Ihre, MD,* Stockholm, Sweden; *John LoGiudice, MD,* Oak Park, Ill; *Lazlo Safrany, MD,* West Germany; *Fred Silverstein, MD,* Seattle, Wash; *Robin H Teague, MD,* Liverpool, England; *Francis Tedesco, MD,* Augusta, Ga; *Jack A Vennes, MD,* Minneapolis, Minn; *Jerome D Waye, MD,* New York, NY, and The Medical College of Wisconsin Faculty

Approved for 23 credit hours of Category I of AMA and 23 elective hours of AAFP. Fee: $300.

Info: Joseph E Geenen, MD; Walter J Hogan, MD, GI Section, 8700 West Wisconsin Ave, Milwaukee, Wis 53226. Phone: 414/291-0813.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1981-1992

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel. Starting in 1982, the new Hyatt Regency will be the headquarters hotel.

1981—March 26-28	**1987—March 26-28**
1982—May 13-15	**1988—April 28-30**
1983—March 24-26	**1989—April 13-15**
1984—March 29-31	**1990—April 26-28**
1985—March 28-30	**1991—April 18-20**
1986—April 17-19	**1992—April 23-25**

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FEBRUARY 1981

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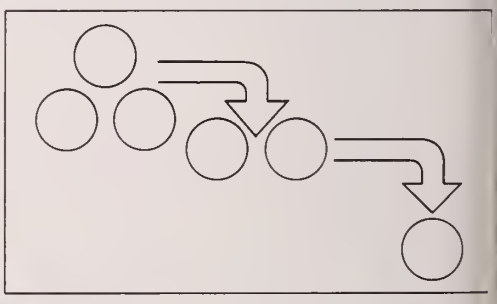

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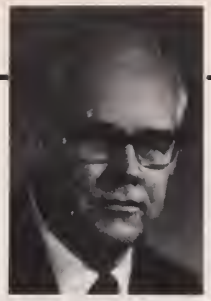
President's Page



Russell F Lewis, MD

AMA

HAVING JUST returned from San Francisco and my fourth meeting of the AMA House of Delegates in the past two years, I would like to share with you some of my impressions, because I found its meetings and discussions most enlightening.

IMPRESSIONS:

1. The AMA's House of Delegates functions as a truly democratic organization, with a few obviously built-in inefficiencies as a result. It functions much as the House of Delegates of the State Medical Society, but to me in a more impressive fashion, simply because most of the speakers were extremely articulate individuals.

This year I sensed several changes from my experiences of 1979 when I felt a certain element of hostility on the part of some of the delegates toward the Board of Trustees. This year there was no sense of that, and I had to conclude either I was wrong last year or there has been an improvement in communications. The delegates acted responsibly, they referred freely problem areas to the Board of Trustees with a sense that the job they required would be done. They listened to reports from, and advice from, the trustees as a whole, and individually. Nevertheless, when it came to the establishment of policy, there was no question but what the delegates felt that was their responsibility, and they took it. At times they overrode recommendations from the Board or the reference committee, or both, particularly on matters of principles.

2. At each roll call there were 278 out of the 279 delegates in their seats at each meeting. The American College of Surgeons had resigned from the House; however, that resignation has not been accepted and that constituted the vacant seat. An effort is being made by the delegates, who also belong to the American College of Surgeons, to resolve those differences. The attendance indicates what was also observed that these physicians are hard workers.

3. The AMA is a well organized and managed federation. All the meetings have gone very smoothly with fewer minor problems than usually encountered. It was also obvious from all the reports by all the individuals that we now have deep respect on the part of those physicians involved with the organization for the entire staff responsible for managing the AMA going into the 1980s.

4. It is an emotional organization, which surprised me. It was stated that there is almost a 20% turnover in the House every year, and yet there was a sense of family about this group of individuals, most of whom seemed to know each other on a first-name basis. The emotion that came through to me was that of love and respect. I felt myself to be an outsider, but I was touched by the inaugural ceremony of Doctor Hunter as the new President in July of this year, and even more so at the time of the election of Doctor Cloud as President-elect. The contest in July between Doctor Cloud and Doctor Ballantine for that position was fascinating. I heard nothing but excellent statements from everybody concerning both of the individuals. It was obvious that one would have to lose, and when it was announced that Doctor Cloud had been the winner, you could sense the immense respect and love and sorrow for Doctor Ballantine. It was my impression that the primary deciding factor was the fact that Doctor Cloud presented a younger image to the organization, which seems to be an important consideration for the AMA.

5. *Actions:* Perhaps the most important action taken in the two years was the revision of the Code of Medical Ethics. It had been discussed repeatedly. The acceptance of the new Code was not a happy one in the eyes of a high percentage of physicians, but it was accepted knowledgeably as the best reasonable proposal that could be made under the threat of legal repercussions. To me the House acted very responsibly.

6. *Membership:* Obviously the mood at San Francisco was one of pleasant anticipation, with hopes that the new administration would find ways to reassess some of the annoying regulations that have crept into being over the past many years. Yet I sensed there was a concern because membership in the AMA, while it is at an all-time high numerically, has not kept pace as well as we would like insofar as the percentage of potential physician members

is concerned. I also perceived a concern that perhaps without the so-called "common enemy syndrome," there was a fear that there might be a falling away from our present level of membership. The fact that the majority of AMA dues goes to support educational programs should be emphasized, because in the long run that is still deemed by organized medicine as its primary function. In the socio-economic area it would seem that people are beginning to think that perhaps the medical profession, considered by so many to be just negative, really was one of concern, and that some of the so-called progressive ideas that sounded great to legislators have now been shown to be probably poorly conceived because of their lack of successful function. It should be apparent that despite the move toward consumer involvement, particularly with governmental promotion of this concept, that in the health field in order to achieve the best results medicine has to be involved.

Despite my recent editorial recommending that the State Medical Society do away with unified membership, I personally have become much more convinced of the value of the AMA to medicine, but even more so to the American public. I would ask that those of you that are critical of the AMA, and there are many, reexamine this issue in light of what has been happening in the last few years. To me, having observed the AMA as closely as I have for two years, the conclusion has to be that it's a different organization than I believed it to be ten years ago, and I am convinced that the present AMA can and will be responsive to our needs. I would heartily recommend meaningful participation in the AMA on the part of all physicians in this state. ■

Target MD

IT'S A LONG haul, at least eight years of education, until one is awarded a doctor of medicine degree. However, the University of Wisconsin-Milwaukee (UWM), in cooperation with the Medical College of Wisconsin (MCW), offers an accelerated premedical program for superior ability students which gives participants extraordinary preparation for the rigors of medicine.

The program—Target MD—includes three years of study at UWM and four years at MCW, states Helen Kittsley, UWM Target MD advisor and office coordinator. After completing the three undergraduate years, the science courses taken during the first year at MCW complete the UWM bachelor of science degree.

Since the beginning of the program in Fall 1975, UWM has admitted 30 students annually to the program, while MCW has reserved 20 spaces each year in its freshman class for Target MD students. Admission to the UWM program thus does not guarantee admission to MCW, although all participants are interviewed by the medical school admissions committee.

This cooperative effort between UWM and MCW was begun to develop a program which would eliminate the artificial rivalry among premedical students and give them a strong preparation for MCW. "We wanted to develop a program which would emphasize education rather than grades," explains MCW Dean of Student Affairs Paul Rosenfeld, MD. The Target MD students have developed a very healthy spirit of cooperation. "Another benefit of the program," Doctor Rosenfeld states, "is that it keeps the highly qualified students in Wisconsin, and they will probably stay to practice in the state."

Target MD students are assigned a MCW advisor as soon as they enter UWM, Doctor Rosenfeld says. Besides meeting with the advisors the undergraduate students participate in six seminars throughout the three years, according to UWM professor Richard Dittman who is a member of the Target MD program and admissions committees. These seminars are team-taught by UWM and MCW faculty. Professor Dittman says the seminars cover such topics as the history and social aspects of medicine and medical ethics which many premedical students never study.

Another benefit of the program, Professor Dittman states, is that many of the science classes are specifically designed for Target MD students. "For example, students start working on cadavers during their first year of the biology curriculum."

"One of the reasons the program was established was to give undergraduates a much wider background than one of pure science," Professor Dittman says. Because of the academic demands and the early exposure to medicine, Ms Kittsley says most students have a better idea of what it takes to be a physician and either affirm their choice or choose a new career before going to medical school.

Besides the academic work, Ms Kittsley says that during the second year at UWM, Target MD students must take the Medical College Admissions Test (MCAT) which is one of the factors that determines admission to MCW.

There are several criteria for admission to the program, Ms Kittsley says: Students must be in the top 15% of their high school class, have a high American College Testing Program (ACT) and UWM placement scores. Then students must be interviewed by members of the UWM and MCW faculty.

"We look for someone who has had rigorous college preparatory courses in high school, is mature, well-rounded, has good social skills and is a caring individual," Ms Kittsley says. Once accepted to the program, she says the only requirement is that a student maintain a B average.

For more information write Helen Kittsley, College of Letters and Science, UWM, PO Box 413, Milwaukee, Wis 53201; or call her at (414) 963-5877. Applications for the program must be submitted to Ms Kittsley by March 31. ■

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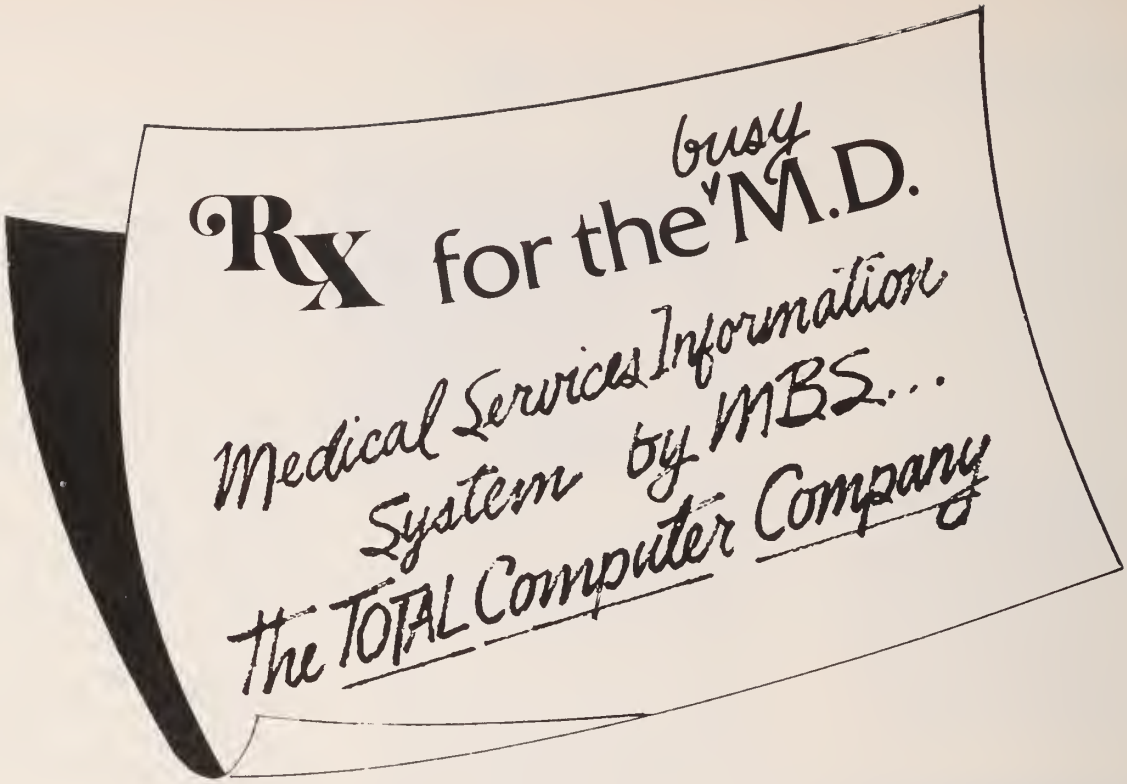

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Editorials

WAYNE J BOULANGER, MD, *Editorial Director*

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Second opinion and Title XIX

CHANCES ARE, before this is published, the legislatively mandated second opinion program for Title XIX will have been put into place.

Wisconsin's Title XIX budget problems are monumental, and the need to cut back on any services which might be nonessential is obvious. Even though physician services amount to only around six percent of the total, one can readily envision substantial cost-cutting if the program functions as the Legislature hopes.

Just how a second opinion program will work in Wisconsin is difficult to predict. There has been quite a bit of experience nationwide with second opinion programs the past two years. From the point of view of supporters of such programs, utilization of the service has been disappointingly low so far, in spite of the fact that about 70 percent of the Blue Shield plans offer it. But when the second opinion has been sought, however, the recommendation in favor of surgery has been upheld only about 70 percent of the time. If these figures are accurate, the Legislature's insistence that the second opinion be mandatory can be readily understood. Probably when second opinion is applied to all prospective surgical situations, instead of only one or two percent of them though, the rejection rate won't remain anywhere near as high. And of course we can never know how many patients will never have an operation recommended simply because there is a mandatory second opinion program. This may be the biggest money-saving feature of the program.

But regardless of the uncertainties, second opinion in Title XIX surgery is here. Although there will be some inconvenience for surgeons and patients, we might as well cooperate as good-naturedly as we can. My plea would be that it be continued only if it provides meaningful savings. It shouldn't take too long to find that out.—WJB

Senior physicians

IN OCTOBER 1980 a group of physicians met in Madison at the Wisconsin Retired Physicians' Convention. However, it turned out that many of these older doctors were far from retired and the group adopted the name of "Senior Physicians."

Some of the "Senior Physicians" have retired completely from practice and others have modified their practices. For example, some have given up surgery, others have given up their offices and are doing hospital-based surgery. Some devote their time to such diverse hobbies as woodworking, scuba diving, traveling, taking up golf at age 75, and one is doing graduate work in horticulture. Several are teaching in medical schools.

The important thing is that they are doing *something*. It is essential that this talent bank be utilized in some productive way. Hippocrates advised his fellow physicians that "life is short, art is long, experience is difficult." Experience is the key word, and this is something that cannot be learned in medical school.

Dr Thomas Leonard, who spearheaded the convention and campaign for the "Senior Physicians," is to be commended for his effort. The new organization should help older physicians adjust to a change of pace and at the same time utilize the vast experience of this talented group.—VSF

Editor's note: Appearing elsewhere in this issue is Doctor Leonard's presentation at the Senior Physicians Association meeting last October. It is the first in a series of articles to be prepared by senior physicians.

Drugs with honors

IN THE 1960s he was "experimenting with drugs" and was threatened with deportation on a drug charge.

In the early 1970s he was on an alcohol and drug binge that lasted 18 months. At that same time his estranged wife was associated with a topless cellist, which brings bizarre and provocative thoughts to mind.

In December 1980 he was assassinated. His assassin also experimented with drugs before the age of 15. This drug culture was something that was condoned by the assassin's idols including the victim. There were two suicides among the young mourners. In recent years six of the victim's musical peers died of overdoses of drugs. The victim left an estate estimated at $235 million. What a distorted sense of values!

Now some misguided politician wants to make John Lennon an honorary citizen of the United States posthumously. Instead of adulation and cannonization, condemnation would be more appropriate for those individuals who stimulated and condoned the use of drugs among young people in the last two decades.—VSF ■

Impaired physician update—1981

Gerald C Kempthorne, MD, Spring Green, Wisconsin

AN IMPAIRED PHYSICIAN Program has been actively supported and sponsored by the State Medical Society of Wisconsin since early 1977. This function has been assigned to the Society's Commission on Mediation and Peer Review for implementation and ongoing review. Now that the program is in its fourth year of operation, it seems appropriate to update physicians and the public on changes and progress in the program.

The State Medical Society's Council recognizes its responsibility to colleagues and continues to encourage development of a dynamic program for *all* Wisconsin physicians including those who are not members of the Society.

Many physicians have benefited through the years by confrontation, helpful intervention, and periodic follow-up. Many programs have been developed to increase the "awareness factor" for the membership as well as the public. Articles have been published in the *Wisconsin Medical Journal,* authored by the Chairman of the Commission and an expert in the field of alcoholism, Roland Herrington, MD of De Paul Rehabilitation Hospital in Milwaukee. The same persons spoke to physicians who participated in the Health Science Telephone Conference for Physicians on Dec 19, 1979. An informational booth on the Impaired Physician Program has been staffed at the Society's annual meetings in Milwaukee. Panel discussions also were conducted at these meetings in 1979 and 1980 covering the entire range of impairment problems.

In 1979 the Council adopted a patient brochure for use in physicians' offices relative to complaints about physicians. The Society took a positive stand at that time and encouraged physicians to distribute these brochures to their patients. The brochures received broad acceptance by the public; they are still available to physicians.

Each year the Society's House of Delegates received a report from the Commission describing the activities of the Impaired Physician Program. Each year the House praised the quiet and successful achievements of the Commission's effort in this program.

Recently the Council adopted a new protocol procedure for conducting the Impaired Physician Program. It clearly describes each step of the process of handling a physician impairment problem with full recognition of the due process concept. Briefly, any responsible person can inform the Impaired Physician Program committee of a concern by calling the State Medical Society in Madison: (608/257-6781 or toll-free 800-362-9080). Staff assigned to receive this information will consult with the Commission chairman for early action on the case. However, before action is taken on any case the complaint is evaluated for accuracy. Once it is determined that a potential problem exists, a confronter team is selected to meet with the involved physician. From that point a process evolves which hopefully will assist the physician to recognize the impairment and accept a treatment plan, leading to a recovery phase that returns the physician to a successful practice.

During the past years of program development, many conferences have been held with various concerned parties. A report on the Impaired Physician Program was presented to Society leadership at a Leadership Conference of 1979 in Madison. Meetings with legislative leaders and the State Medical Examining Board also have been helpful. There have been meetings on quality assurance within the Society, discussions on elderly physicians, conferences with experts in the field of impairment, public presentations, and considerable media exposure regarding the past, present, and future concerns for the impaired physician.

Leadership of the State Medical Society, in concert with leaders in the Legislature and the Medical Examining Board, recognized the importance of the mission of the Impaired Physician Program. To broaden the scope of the Society's mission and establish goals in further development of the program, the Council adopted the joint proposal of a ***Statewide Impaired Physician Program*** between the State Medical Society of Wisconsin and the State Medical Examining Board. The purpose of this agreement was *not* to exercise the disciplinary arm of the State

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Doctor Kempthorne is a Councilor and Chairman of the State Medical Society's Commission on Mediation and Peer Review, and is cochairman of the Coordinating Council on Physician Impairment along with Rudolf W Link, MD. This article has been prepared at the request of the Coordinating Council, representing the Society and the Medical Examining Board. Copyright 1981 by the State Medical Society of Wisconsin.

of Wisconsin but establish and develop a Coordinating Council on Physician Impairment between the two bodies.

The Council's goals are to establish policies and guidelines, coordinate the work of the Society and the Board, promote educational programs, and provide direction to the State Medical Society's Impaired Physician Program.

The agreement provides for establishment of an Impaired Physician Committee as a committee of the Society's Commission on Mediation and Peer Review. This committee will be made up of one or two physicians from each councilor district as *trained* confronters. The committee will continue the original goals of the Society's Impaired Physician Program but will focus attention on educational programing as well. Physician confronters will receive training at an institution qualified to teach the techniques of intervention and after-care.

The Council of the State Medical Society has budgeted an appropriate amount of funds to facilitate training of eight confronters. The process of selecting these individuals already has begun.

The Coordinating Council has met on two occasions. The State Medical Society is represented by Gerald C Kempthorne, MD, Spring Green; Harry F Weisberg, MD, Milwaukee; and John B McAndrew, MD, Oshkosh. The Medical Examining Board is represented by Rudolf W Link, MD, Madison; Walter Washburn, MD, Madison; and Ms Gwen Jackson, Milwaukee. The primary function of this body will be to conduct a thorough study of the extent of impairment among Wisconsin physicians and to assess the efficacy of the Coordinating Council and the Society's Impaired Physician Committee after one year of operation.

The impaired physician is written about, televised, dramatized, and generally discussed at such length so as to suggest there is a major problem. However, one must keep the word "impairment" in perspective. It simply means that a personal problem of the physician interferes with satisfactory performance in his/her profession. Impairment includes alcoholism, drug abuse, senility, psychiatric disorders, and physical disorders. The hope of the future is to recognize and treat these disorders before they affect patient care. More importantly, the ultimate goal is to implement education and prevention programs largely to eliminate the potential for the problem.

Obviously if there is a significant impairment problem among physicians, it is certainly high time to recognize the extent of the problem and act on it. This is being done in many different ways. In addition to the new agreement and past activities in the Society's Impaired Physician Program, impairment problems are being dealt with by hospital medical staffs, specialty societies, larger county medical societies, and rarely on a one-to-one basis. There are many treatment facilities ready, willing, and able to treat physicians once they are introduced to the program.

The Society is establishing an Impaired Physician Committee to be made up of one or two physicians from each councilor district as *trained* confronters. The process of selecting confronters already has begun. Physicians are urged to contact the Society if interested in becoming a confronter, or call Doctor Kempthorne at 608/588-2502.

It is crucial to the success of the impaired physician concept to clearly recognize the importance of helping the physician handicapped with a problem of impairment. It is totally unrealistic and almost cruel to permit a colleague to go unassisted with impairment despite denial and recalcitrance—let alone concerns for the patient public.

The problem of impairment cannot be tolerated. It is important, therefore, to proceed with the goals of the new Coordinating Council. A minimum of one physician from each councilor district interested in working with impaired physicians must be recruited for training. A concerted effort in this direction will be promulgated in order to establish a fully operational, statewide program. It then may be possible to determine whether the problem is as great as some segments of society believe. Certainly it should be the posture of the State Medical Society to address the issue in a forthright manner despite the extent or degree of the problem. ■

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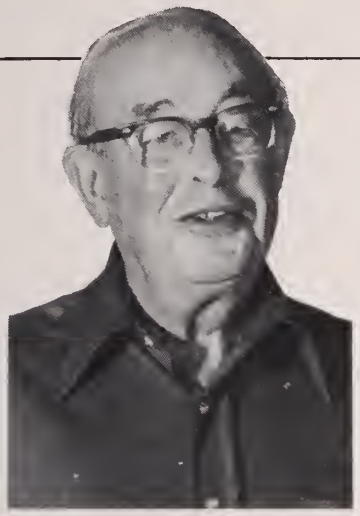

Relegated to obscurity? No!

"We who belong to this century, who have been a part of it have this knowledge within us and this maturity of judgment that should not be so readily cast aside . . . We, as a basis of our thoughts in this organization, must do something about that. And we will."

Thomas A Leonard, MD, Madison, Wisconsin

SOMETHING that is very dear to me is the problem of maturity and its relationships to all of us, to the State Medical Society, and to all of those institutions with which we have worked for so long. Why is it that maturity is cast aside like some leper's disease? Why is it that those who possess it are relegated to immediate and permanent obscurity—simply because they have reached a chronological age? An age which is usually categorized as that of 70.

I questioned why it was that one minute before midnight on one's 70th birthday one is competent, but one minute after midnight on that day one ceases to be so. I was concerned about this factor because many hospitals in the state have had a mandatory retirement clause at age 70. Physicians were told, sometimes undiplomatically, that at age 70 they could no longer care for patients in their hospitals—often times in hospitals where they had spent their entire professional lives.

In making inquiries about this, I found that the Supreme Court of the United States had decided that this was illegal. This was discrimination. That 70-year-old physicians who were competent had the same rights and privileges as those who were 30 and competent. Because of this ruling at least one hospital that I know has changed its bylaws, now making it possible for a physician at age 70 to be judged by a jury of his peers. If he is judged competent, he can continue because health and well-being of the patient is paramount.

But the well-being of the mind of the physician who is competent is also of paramount importance to me. I'd like to quote one of my favorite playwrights, George Bernard Shaw. One of his characters put it something like this: "Life is no brief candle to me. It is a flaming torch which I have gotten hold of, and I want it to burn as brightly as possible before passing it on to future generations."

There have been many torch bearers in the history of Wisconsin medicine. Many of you who are here today, have lived through a great portion of this century—one of the greatest centuries in terms of medical progress. We know that history and we have lived that history. There is importance in this, because all advance, all future progress, has to depend on the history of the past. We who belong to this century, who have been a part of it, have this knowledge within us and this maturity of judgment that should not be so readily cast aside. We may be a little weak in the knees and our muscles may have caused us to falter a bit, and we may be a little dim of vision, but for the most part physicians who have grown old still have that integrity of mind to make contributions if they are asked and permitted to do so. This matter of being relegated to obscurity is wrong and it cannot continue to be that way. We, as a basis of our thoughts in this organization, must do something about that. And we will. ■

Presented before the Wisconsin Association of Senior Physicians convention, October 18, 1980, at the State Medical Society of Wisconsin, Madison, Wisconsin. Copyright 1981 by the State Medical Society of Wisconsin.

DR THOMAS A LEONARD is an emeritus clinical faculty member of gynecology and obstetrics at the University of Wisconsin Center for Health Sciences. He is known throughout the country for his work on the Maternal Mortality Study Committee of the State Medical Society of Wisconsin. In 1977 he received the State Medical Society's "Distinguished Service Award." Doctor Leonard is a founding member of the American College of Obstetricians and Gynecologists and a founder of the Wisconsin Association for Perinatal Care which a few years ago created an annual award in his name. Although retired from active practice, Doctor Leonard continues to participate in the medical community. Doctor Leonard spearheaded the formation of the Wisconsin Association of Senior Physicians. Through this "Senior Physicians" feature Doctor Leonard hopes to provide a communications mechanism for the Association members to relate their views on current issues to their younger colleagues. The next article will feature Dr Howard Correll of Arena who will discuss "CME credits and medical licensure."

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Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

WisPRO—friend or foe?

HAVING SERVED on two WisPRO (Wisconsin Professional Review Organization) subcommittees over the past few years, I have seen a gradual evolution. Originally the majority of data concerned length of stay, dollar costs, and utilization rates. Rarely was quality addressed. At that time many of my colleagues felt that WisPRO was certainly not a friend, only a cost-containment mechanism. It seemed, at that point, that for this agency to justify its continued existence, it would have to save more dollars than it consumed by reducing utilization, *or* have a strong program relative to the quality of care. The director of the agency indicated that two-thirds of the total effort was devoted to developing data relative to cost, and one-third relative to quality. In the last year to year-and-a-half the data relative to quality started to appear. If properly utilized, this data will be of benefit to our patients.

An enormous amount of information has been accumulated. How this information is used is crucial. Data regarding utilization needs to be very closely scrutinized by physicians who are familiar with the nuances of medical practice before any judgmental decisions are made. There may be a few chronic offenders who can be justifiably classified as those who are over-utilized. There are also those who *appear* to be over-utilizing medical service because of their peculiar practices relative to the age of their patients. Certainly an older physician can have a preponderance for those patients in the Medicare age group because he is a good physician and his patients continue to see him as they grow old.

An example, who is a friend of mine and highly skilled and certainly one of the most reputable physicians I know, was singled out as being one of those who over-utilized medical services, based on his practice profile. I think this misunderstanding could have been avoided had the data been better interpreted.

There is a probability that WisPRO can become a friend to the physician and the patient, by addressing quality of care, by defining needs which can be addressed by remedial continuing medical education, and also contain the cost of medical care. I would hope the physicians in the State of Wisconsin withhold final judgment as to whether WisPRO is friend or foe until the agency has reached maturity.

Richard D Sautter, MD
Marshfield, Wisconsin

Cesarean deliveries

IN THE NOVEMBER 1980 *Wisconsin Medical Journal* appeared your (VSF) editorial entitled "Cesarean deliveries" in which you departed to some degree from your usual reasoned approach to medical problems. You commented on an acquaintance of yours in pediatric practice telling of the 25 to 30 percent cesarean section rate at his hospital and his necessity to attend these, sometimes several times in a single night.

I do not have statistics available, but I now see many fewer newborns with evidence of perinatal asphyxia or head injury secondary to traumatic deliveries (hung up breeches and difficult forceps deliveries). Consequently I also see many fewer children affected with cerebral palsy secondary to perinatal events. It is my impression this is in large part due to obstetricians performing cesarean sections with less stringent indications than when I first was in practice twenty years ago.

I, too, do not particularly enjoy having my busy office schedule or good night's sleep interrupted by the necessity to attend a cesarean section and care for the newborn infant whose life may well be immensely enhanced.

I would rather throw roses than stones at my obstetrical colleagues for this particular change in their practice.

Gerald E Porter, MD
Marshfield, Wisconsin

* * *

Editorial comment: I'm sure everyone will agree with your comments about the improvement in the neonatal situation relative to birth trauma, and there have been countless articles about the relaxation of the former requirements for doing cesarean sections. Conversely, there have been reports of increased undesirable sequelae with cesarean neonates.

I recently reviewed a report covering a five-year survey of obstetric practice in a rural Wisconsin hospital. In this series the percentage of cesarean sections was 9.5 (5.7% primary and 3.8% repeat sections). The 1980 edition of *Williams Obstetrics* reports a range from 10.1 to 22 percent in the years 1978 and 1979. However, most of these were reported from large institutions. The statewide range in Wisconsin is just over 10 percent.

I still think 25 to 30 percent cesarean section rate is high. What is the percentage at the Marshfield Clinic?—VSF

Medical treatment praised

As a visitor in Hartford, Wisconsin, I wish to inform the Medical Society of the outstanding medical treatment rendered in the Hartford Memorial Hospital and the Hartford Clinic. Dr U V Gupte was on duty September 1, 1980 when the hematoma on my right hand and arm, and my blood pressure of 240/120 alarmed not only me but also caused concern for my family. I was grateful that the stat admission did not have me placed in a bed in the corridor. Doctor Gupte is certainly a dedicated physician.

Everyone I met who had anything to do with my medical care showed thoughtful attention as hospital employees.

The Hartford Clinic I was referred to prior to our departure from Hartford, Wisconsin and in particular Dr W C P Hoffman, who procured the final summary of my hospital admission in order to thoroughly evaluate my problem for a safe automobile trip to Rhode Island, impressed me as a very dedicated doctor.

There are so many reasons to complain in this modern age that I felt praise for services rendered should be forthcoming, because I was a stranger and none of these people would ever see me again. Please place a copy of this letter of commendation in their personnel files.

Eleanor Ouimette
2132 Cranston St
Cranston, Rhode Island 02920

SURREBUTTAL

RE: "The HMO—caveat emptor?" (Rowe)

I read with some interest the letter by Dr George G Rowe entitled, "The HMO—Caveat Emptor?" (*WMJ*, November 1980). I find it incredulous that a physician of the scientific stature of George Rowe could write such a commentary regarding the HMO concept.

The presentation of his "case report" is anecdotal. Were I the sociologist quoted, I would be furious at being protrayed as either a fool or as being so dependent as to always consult a father image.

His errors in reason in this commentary are too numerous to mention individually, however, some are:

1) It is obvious from the sociologist's report that he was cared for by an incompetent physician. The implication that all physicians in an HMO are of the same quality is unreasonable. "If the sociologist had consulted a physician outside an HMO," what guarantee is there that he would have received the best possible medical care?

continued

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*Data on file Parke-Davis Marketing Research Dept.
**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*, IMS America Ltd., September 1980.

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Hemorrhoidal Suppositories with Hydrocortisone Acetate
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Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
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Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
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Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
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2) To ". . . get back into the mainstream of medical care." The sociologist's contention, with which Doctor Rowe agreed, is that the HMO concept is outside the main stream of medical care, and expresses his lack of contact with reality. I am certain Doctor Rowe's fund of medical information is extensive, but he needs to become better informed regarding nontraditional methods of providing health care. He is obviously oblivious to the concerns of nearly everyone else regarding the rapid escalations of the cost of health care.

3) His statement regarding giving $1,000 to an auto mechanic, grocer, etc, to get all services needed for a year is simply further evidence of his lack of knowledge. What would be ludicrous for the case of one might work very well for 1,000, 10,000, or 50,000. For instance, for an annual fee you can participate in the benefits afforded members of the American Automobile Association or almost any other insurance carrier, a concept which continues to elude Doctor Rowe.

I know of no physicians associated with an HMO who have ever suggested that the quality of care be compromised. The contention that there are no ways to conserve costs in the delivery of medical care and still maintain quality is simply naive.

Additionally, I wonder whose little voice is quoted in saying, "90% of patients will get well no matter what you do . . ." Certainly, I have not heard this little voice. Perhaps Doctor Rowe has exclusive rights to this genie.

The concept in an HMO is that if physicians do a really good job in the judicious use of services and preventive care to help people stay healthy, it rewards all—the physician, the patient, and the taxpayer.

"Federal support for a local HMO provides subsidized medical care for a few at the expense of many." I find this somewhat amusing. One could substitute "university" for "HMO" and lose none of the truth. I am amazed that Doctor Rowe has a problem with this concept, as I certainly have none.

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Also, I was shocked at the apparent contempt for the physician-at-large. The attitude that physicians in an HMO would compromise the quality of care in order to line their pockets with dollars, demeans a large number of very good physicians. Equally sophomoric is the attitude that physicians have no role to play in cost containment. This is exactly what has brought the medical profession to the troubled times it has today. The lack of understanding regarding the financial structure of our new industrial complex shows a lack of contact with the real world.

I am a strong advocate for the decrease in the cost of medical care, but even a stronger advocate for preventing any erosion of quality of medical care. Doctor Rowe's contention that excellence of care can be obtained only at great cost is untrue. His prescription for avoiding HMOs causes me to wonder which of us is out of the mainstream of medical care. Caveat physicus.

Richard D Sautter, MD
Marshfield, Wisconsin

* * *

Editorial comment: The original letter by Doctor Rowe (*WMJ*, November 1980) and subsequent correspondence from Doctors Lewis (*WMJ*, December 1980) and Sautter (above) illustrate nicely the gap between private practice advocates and their counterparts in the HMOs. There always have been ideological differences between the two schools, but the polarization has been worsened since government has taken sides and chosen to write legislation favoring HMOs over private practice systems. Were it not for that favoritism, there would be much less rancor, and perhaps more ready acceptance of the HMO concept by the private physician.—WJB■

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The Clinical Laboratory Improvement Acts

A perspective of the process politic.

George W Kindschi, MD, Monroe, Wisconsin

Part I of a two-part series.

IN 1967 THE "Partnership for Health Amendments" became law. Section 5 of this law became known as the "Clinical Laboratories Improvement Act of 1967." This paper explores the origins of the legislation and briefly describes the political process behind its passage.

"But nothing is so easy, as to find fault with human institutions; nothing so difficult, as to suggest adequate practical improvements. It is to be lamented, that more men of talents employ their time in the former occupation, than in the latter."

Thomas Malthus
The First Essay on Population
1798

THOMAS MALTHUS was not referring to the medical profession when he wrote this general comment on the fragility of human institutions, but clearly this observation is applicable today to the Federal government's constant tinkering with the healthcare delivery system found in the United States. "Too big," they say and add, "too costly . . . too inefficient . . . too much control by the doctors." Yet, most of the people within the Federal government who say this agree that healthcare in the United States is probably the best in the world. Strangely, many of these same people staunchly believe that, through government regulation and control, the healthcare delivery system can become even better. It should be noted that "making things better through regulation" has met with very few successes in the past.

This paper will attempt to analyze the motives behind, and the political process of the passage of, one of these regulatory laws, the Clinical Laboratories Improvement Act of 1967. It is hoped that a clear picture of the political process behind one piece of health legislation will aid in the understanding and rational modification of future, similar pieces of legislation.

To put these thoughts in perspective, one must go back to the late twenties and early thirties when methods for culturing common bacteria and counting blood cells first became routinely available in larger hospital centers. Soon basic chemistry tests including blood sugar and nonprotein nitrogen also could be done. At long last the practicing physician could identify and quantitate a few disease states in a rational and scientific manner even though these tests took many hours to complete. No longer would guesswork play a dominant role in the practice of medicine.

Physicians began to ask for additional tests to aid in the diagnosis and treatment of other diseases and to evaluate the functional status of organ systems. They demanded that the tests be performed more rapidly and more economically. Most of these physicians were not concerned with precision, accuracy, or quality control, but took for granted that the answers they received were correct. Laboratories, both commercial and private, took this challenge very seriously and progress toward more rapid, accurate, precise and comprehensive clinical testing was dramatic.

Since the laboratory had had such a minor part in the practice of medicine for such a long period, the sudden explosion of technology in the fifties and sixties was not accompanied by personnel who were trained or experienced in the growing complexity of laboratory medicine. Demands were placed on technologists schooled in laborious manual methodology to shift abruptly to new, highly sophisticated analytical techniques. The existing schools couldn't keep up with the demand for technologists and, to support the new and expanding laboratories, personnel with a lesser degree of training often were hired. This inevitably resulted in a decline in the quality of the performance of these labs.

The lay press was the first to pick up and publicize this developing problem. As early as October 1960, essays appeared in both *Time* and *Newsweek* assailing the commercial laboratories and accusing them of producing inaccurate tests with disastrous results. There were other articles, too, but the most condemning one was written by Alice Lake in *McCall's* in May 1965 and then was republished in the October 1965 *Reader's Digest*. The article had a tone of sensationalism and cited "shocking" errors in Pap smears, blood typing, and chemical analy-

Part II will appear in the March issue. Reprint requests to: George W Kindschi, MD, 1515 Tenth St, Monroe, Wis 53566 (phone: 608/328-7000). Copyright 1981 by the State Medical Society of Wisconsin.

sis. She isolated the problem in a rather simplistic manner:

> "Who is to blame? Three groups: the laboratories, the doctors who patronize them and the lawmakers who fail to protect the public."

She stated that the commercial laboratories were the worst offenders and noted that many of these labs were staffed by people who didn't know what they were doing. She also claimed that the worst labs were in New York City.

A footnote in the *Reader's Digest* article stated that the original article published in *McCall's* had been the impetus for Senators Javits and Murphy to include a section on the licensing and regulation of laboratories in the Senate bill "Partnership For Health Amendments of 1967." In actual fact the proposal for licensing and regulation had come from the executive branch of the government and had been introduced first in the House of Representatives. Therefore, the full impact of the lay press on the origin of CLIA '67 is not clear.

"The Partnership for Health Amendments" was introduced into the House by Rep Harley Staggers as HR 6418. The general tone of the bill was that of cooperative planning. The goals of the act were

> ". . . to amend the Public Health Service Act to extend and expand the authorization for grants for comprehensive health planning and services, to broaden and improve the authorization for research and demonstrations relating to the delivery of health services, to improve the performance of clinical laboratories."

Section 5 of this bill dealt directly with the licensing and regulation of clinical laboratories. Aside from the laws requiring licensing of some of the health professionals, this was the first piece of legislation directed at regulation of an entire sector of the healthcare industry. The original intent of this section of the bill was to license and regulate all clinical laboratories, but when estimates exceeded 15,000 laboratories that would have to be included, a decision was made to apply the law just to the nearly 1,000 labs involved in interstate commerce. This decision was based in part on logistical terms, and in part on the fact that precedence had long been established for Federal control of interstate commerce. Attempting to regulate commerce within a state would be new and possibly unconstitutional. This was a very practical approach to a potentially overwhelming charge issued from the executive branch. In retrospect, however, it wound up regulating those labs that needed it the least.

The tone of the subcommittee hearings was calculated to drum up popular support for the bill since there was little public outcry for action. Studies were cited by witnesses which, if taken at face value, would certainly have indicated that the clinical laboratory was an error-prone place insensitive to the needs of both the patients and the physician. Its main function seemed to be a moneymaker for its owners.

The Honorable Wilbur Cohen, then Undersecretary of Health, Education, and Welfare, testified in favor of the bill. He quoted a study made by the Center for Communicable Disease in Atlanta:

> ". . . as shocked as I was when studies by the National Communicable Disease Center, and others, indicate that unsatisfactory performance is demonstrated by 10 to 40 percent of laboratories in bacteriologic testing; by 30 to 50 percent in blood grouping and typing; by 20 to 30 percent in hemoglobin measurements; by 40 to 80 percent in differential characterization of blood cells; and by 20 to 30 percent in measurement of serum electrolytes."

He went on to add ". . . erroneous results are obtained in more than 25 percent of all tests." What Mr Cohen did not say was that these data were derived from 67 Federal medical laboratories including Indian Bureau hospitals, Federal prisons, Marine hospitals and other Federal dispensary and infirmary laboratories. It is ironic that the laboratories from which the data were obtained would not be affected by the law, but, because of their Federal sponsorship, would be totally exempt.

Other proregulatory testimony was offered by WB Manson, MD, PhD, an associate Professor of Clinical Chemistry at the University of Rochester representing the American Chemical Society. He said that he believed in three to five years all the states would have grappled with this problem and would be licensing laboratories. He believed that national standards should be established but didn't offer any suggestions as to how this might be done. He also stated that he felt that labs that met with Medicaid and Medicare requirements should be exempted from the law. His final comments were that proficiency testing should be done on a national basis and that the small office lab should not be exempted from the law.

Rep Tim Carter, a physician himself, told Doctor Manson that he didn't believe the error rates cited in the previous testimony. Doctor Manson replied that it was true and added that if the true value of a test, such as Blood Urea Nitrogen (BUN) is 12 and the answer given by the lab is 18, then it is a 50% error rate. The thinking behind such a statement defies logical explanation. The assessment of laboratory data is made statistically using the coefficient of variation and the standard deviation. These numbers reflect both precision and accuracy and define a satisfactory range into which the assayed values may fall. These methods have been available for years and were in widespread use at the time of this testimony. Thus, the statement of 'an error of 50%'

was not only misleading but also it reflected profound ignorance of data analysis in the clinical laboratory.

Other testimony centered around the qualifications of the director of a large commercial laboratory. Richard Guttmacher, Executive Vice-President of Bionetics Research Laboratory, stated flatly that a physician as the head of a lab would be just a figurehead and that chemists, microbiologists, and businessmen would do a better job. Dr Ernest Simard, President of the College of American Pathologists, did not offer contradicting testimony but simply stated that the pathologists in the lab are not businessmen but are practicing physicians.

Several witnesses challenged the proposed guidelines for the qualification of the technicians and technologists as being unrealistic. The bill as written would have cost many competent people their jobs. Doctor Carter was very sympathetic in stating, "I think these people should have the benefit of a test before ruling them out arbitrarily." The result of this testimony was the inclusion of a provision allowing for a Federally sponsored competency test to be offered to those who had experience in the laboratory, but little or no formal training. This test was offered for more than 12 years and was only recently suspended because of lack of funding.

The bill, with only a few minor changes and additions, was passed unanimously by both the subcommittee and the entire committee and reached the floor of the House for debate on Sept 19, 1967. Only token opposition was offered with most of those rising to speak being in favor of passage of the bill. On September 20 the Partnership for Health Bill was passed by a 395 to 7 margin with 30 members not voting. It was then sent to the Senate.

Sen Jacob Javits had already submitted a bill similar to HR 6418, S 814, which had been sent to the Subcommittee on Health around midsummer. Hearings on the Senate bill had already been scheduled when HR 6418 was passed. The bills were so similar that the subcommittee eventually chose not to consider the Senate version but rather to amend the already passed House bill. Senators Javits and Edward Kennedy were absent during most of the testimony in front of the subcommittee. For the most part the testimony was a repeat of the House hearings with one significant exception: The statement of Morris Schaeffer, MD, PhD, the Assistant Commissioner and General Director of Laboratories of the New York City Department of Health.

Doctor Schaeffer had authored two articles about the performance of the clinical labs in the City of New York. The performance statistics of these lab-

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oratories was abysmally poor. The amount of laboratory error cited indicated that essentially no test was being properly performed. Although these data were impressive and pointed to a severe problem in New York, Doctor Schaeffer implied that this was the situation all over the country. This implication was neither challenged nor verbally accepted by the members of the subcommittee. He continued with the following statement:

> "The statement that erroneous laboratory results are rare is contrary to experience. Every physician, whenever you ask him, can cite at least one recent example of a misleading laboratory report. Many patients can relate how certain of their laboratory tests had to be repeated because the physician had some doubts about the validity of the report. How fortunate for such patients when this occurs, but more often the physician is not so astute. All too often the deadly mistake is buried with the patient."

This accusation of laboratory mediated manslaughter went completely unchallenged! Sen Lister Hill did ask Doctor Schaeffer why the tests were so poor. Doctor Schaeffer replied:

> "The truth of the matter is that many of these (tests) are done very poorly in pathologist labs, because they depend upon technicians generally to do the work."

This statement could lead the casual observer to believe all technicans to be incompetent and the pathologist to be a fool. Doctor Schaeffer closed his statement by saying he believed all laboratories should be regulated and licensed, but preferably through the states.

The bill that finally reached the Senate floor was HR 6418 with 34 minor amendments. It was passed and sent to a conference committee where the House accepted 33 of the amendments. On November 21 the bill was passed by the House by a 349 to 2 margin with 81 not voting. The Senate passed it by acclamation. President Johnson quickly signed the bill and it became Public Law 90-174.

Summary. There was, in reality, a genuine need for CLIA '67; it forced the physicians of the nation to realize the complexity and the dangers of the rapidly expanding medical laboratory. The law was practical, enforceable, and necessary and it established realistic guidelines for personnel standards and quality assurance. In addition it established the need for proficiency testing. This law accepted reality and regulated that which was regulatable. It is considered by most to be a good and effective piece of legislation.

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The tremor syndrome: Is it Parkinson's disease?

Norman C Reynolds Jr, MD, Milwaukee, Wisconsin

BECAUSE OF ITS position as a classical model for the pathophysiology of extrapyramidal movement disorders, Parkinson's disease can be over emphasized in the differential diagnosis of the tremor syndrome and the patient subjected to inappropriate or deleterious treatment. Neurologic conditions with abnormal movements, especially tremors, are confusing in general practice and may be approached uncritically as Parkinsonian variants, rather than as separate diseases. An appreciation for alternatives to Parkinson's disease coupled with a careful physical examination can eliminate needless medication trials and may lead the way to an improving neurologic status.

The classic triad of clinical signs in Parkinson's disease includes a resting tremor, muscular rigidity, and bradykinesia. Although other abnormal movements may occur, the tremor is most apparent as a rhythmic to-and-fro movement in the hands and fingers as if the patient were literally rolling a pill between his thumb and index or middle fingers. The tremor is most apparent in a relaxed posture of the limb, intensifies with emotions or anxiety but may vanish when a small object is picked up with the fingers. The distribution of muscle rigidity is nearly equal in extensors and flexors with passive movement of a joint as distinguished from spasticity, where flexors predominate in the upper limb and extensors in the lower limb. Bradykinesia is a problem of movement inertia. The patient has generally slow gait and total body movements due to difficulties initiating and terminating movements. Movement inertia also appears as a postural instability and when combined with rigidity produces the characteristic Parkinsonian speech. Other features may include mask-like facies, stooped posture with shuffling gait, micrographia, and orthostatic hypotension. Early signs can be useful in history taking: increased vocal pitch or hoarseness, aching pains in neck, back, or limbs, fatigability, decreased spontaneous blinking, a subtle unilateral gait instability, decreased arm swing, tightness in calf muscles, and difficulty getting out of a car.

The imbalance in extrapyramidal circuits in the Parkinsonian state results from a deficiency in dopamine neurotransmitter activity and a compensatory excess in acetyl choline activity in the striatum of the basal ganglia.[1] This is the basis for the use of L-dopa (Larodopa®) or L-dopa containing compounds (Sinemet®) and anti-cholinergic drugs, such as benztropine (Cogentin®) trihexyphenidyl (Artane®), or diphenhydramine (Benadryl®). The pathophysiology of classical Parkinsonism involves deterioration of dopamine secreting neurons with cell bodies in the substantia nigra possibly on vascular, post-viral, or degenerative bases.[2] Iatrogenic Parkinsonism can be induced with the use of dopamine receptor blockers (*ie,* major tranquilizers) or catecholamine depleters (*eg,* reserpine or resperine containing antihypertensive combinations) in susceptible patients, especially the elderly. A common example is iatrogenic Parkinson's disease secondary to prochlorperazine (Compazine®) in an older patient. Its anti-emetic properties often over shadow its identity as a generic major tranquilizer. Iatrogenic Parkinson's disease can be treated by withdrawal of the major tranquilizer or by the addition of an anticholinergic drug. The practice of using anti-cholinergic drugs with major tranquilizers as prophylaxis adds additional imbalance to extrapyramidal circuits and may well increase the risk of developing tardive dyskinesia.[3] This latter condition is not a form of Parkinson's disease but a separate entity featuring abnormal movements in the face, especially the mouth and tongue. The pathophysiology involves dopamine receptor hypersensitivity and cholinergic hypofunction in susceptible individuals secondary to chronic major tranquilizer use.[4] Unless the medication is withdrawn at the first appearance of dyskinesias the syndrome may become permanent. On the other hand, there is evidence that anticholinergic drugs are effective in treating akathisia, another iatrogenic effect of major tranquilizers, featuring an irresistible propensity toward stereotypic movements such as pacing, leg swinging, or marching in place.

Although tremor may not be the most salient aspect in a patient with Parkinson's disease, when a tremor is noticed, a careful evaluation of various tremor components should be made by physical examination. Extrapyramidal tremors are absent during sleep but exaggerated with heightened emotions during the waking state. Persistence of rhythmic movements in an extremity during sleep calls to mind clonic activity seen in continuous partial motor seizures. A limb held in a dependent position with

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Table 1—Tremor syndromes

RESTING TREMOR
- Paralysis agitans
- Symptomatic Parkinsonism
  - Post-encelphalitic
  - Drug-induced (phenothiazines, butyrophenones, thioxanthines)
  - Toxic agents, (Mn, CO)
  - Deep midline tumors
- Primary cortical atrophy (with senile tremor)
- Shy-Drager's disease
- Progressive supranuclear palsy
- Striatonigral degeneration

POSTURAL TREMOR
- Benign essential tremor
- Thyrotoxicosis
- Hypomagnesemia
- Alcoholic withdrawal
- Wilson's disease
- Chronic alcoholism

INTENTION TREMOR
- Cerebellar disorders

muscles relaxed can display a distal resting or "pill rolling" tremor which usually attenuates or even stops with attempts to grasp a small object between thumb and fingers in a patient with Parkinson's disease. On the other hand, the "action tremor" is noted as a concomitant to voluntary muscle activity. If it is enhanced by certain positions (*eg*, arms outstretched with hands held vertically), then the term "postural tremor" can be used. If it is enhanced by reaching to grasp or in finger pursuit maneuvers, then the term "intentional tremor" can be used. If an intentional component is noted without other components of an action tremor, the problem is usually cerebellar dyssynergia rather than extrapyramidal tremor.

The concept of "cogwheeling" or "cogwheel rigidity" is more misleading than it is precise or diagnostic. The term refers to a rachet-like response of the patient's limb to passive movement which can be superimposed on a rigidity with Parkinson's disease. Careful physiologic studies have identified the cogwheel phenomenon in Parkinson's disease as an action tremor unrelated to either rigidity or to resting tremor.[5,6] Cogwheeling is often readily detected in a variety of action tremors. A clinician preoccupied with the term "cogwheel rigidity" can easily mistake a pure action tremor as a sign of rigidity and falsely diagnose Parkinsonism. Many if not most Parkinson's patients do have an action tremor detected as cogwheeling in addition to their resting tremor, and the action tremor may show some postural and some intentional components.

Other signs of Parkinsonism are important in clarifying the diagnosis. In general the other action tremors have prominent postural components and are therefore referred to as "postural tremors" even though cogwheeling or intentional components occur (Table 1). A differential diagnosis of postural tremors can be clarified by history and/or a few simple tests (T_3, T_4, serum magnesium level, serum ceruloplasmin level, liver function studies). The category of benign essential tremor includes both familial and sporadic forms. Senile tremor can appear either as a postural or a resting tremor. Both senile and essential tremor are easily treated with β-blockers (*eg*, propranolol [Inderal®] or metoprolol [Lopressor®], but do not typically respond to anti-Parkinson medication.

Other distinct diseases can be confused with Parkinson's disease by superficially mimicking signs seen in Parkinson's disease. A depressed patient may show an expressionless face and move slowly due to psychomotor retardation. If there is a marked anxiety associated with depression, the patient's physiologic (action) tremor may be exaggerated and produce cogwheeling. Thioridazine (Mellaril®), mesoridazine (Serentil®) or tricyclics often exaggerate tremor. On the other hand, Parkinson's patients are not uncommonly depressed and the use of these same medications for depression can mask a true Parkinsonian syndrome by exerting an anti-cholinergic effect like benztropine or trihexyphenidyl. An accurate assessment of the underlying disease can be made by careful physical examination two to four weeks after medication withdrawal. Another source of syndrome confusion can be the elderly patient with osteoarthritis and senile action tremor. The stiffness secondary to joint immobility can produce a false appearance of bradykinesia and at times even a stooped posture with shuffling gait.

Summary. Although the syndrome of Parkinsonism has well-known classical signs and symptoms, other diseases and other extrapyramidal movement disorders can be confused with the classical picture of Parkinson's disease unless an effort is made to include a broad differential. Examination of the patient in the absence of medications which are known to modify the extrapyramidal system should include a careful assessment of rigidity, movement parameters and especially a consideration of multiple components to a tremor when this is present. Medications which exaggerate or mask a Parkinson's picture were discussed. Specific examples of misleading aspects of physical diagnosis were offered in an attempt to clarify this issue.

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Seasonal occurrence of viruses in the Milwaukee area: 1971-1980

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Introduction. From 1971 to 1980 the Milwaukee Health Department virus laboratory routinely has performed virus isolation and serology tests to diagnose viral infections mainly for patients seen at Milwaukee area hospitals. Compilation of confirmed virus infections from these diagnostic tests indicates that many viruses have well-defined patterns of seasonal occurrence. Our earlier report in this journal[1] showed preliminary evidence for such seasonal patterns. However, since that publication our annual workload has increased significantly and with this increase has come an increased output of confirmed virus infections leading to a clearer, more well-defined pattern for virus infections in the Milwaukee area.

A brief summary and evaluation of our findings from 1971 through April of 1980 is presented for some of the viruses that our diagnostic systems could detect. Those detectable viruses are the enteroviruses, influenza virus types A and B, respiratory syncytial virus, the adenoviruses, the parainfluenza viruses, and the rhinoviruses. Occurrence of confirmed *Mycoplasma pneumoniae* cases is also presented.

Materials and methods. The criteria for specimens and clinical cases included in this study and the interpretation of test results are the same as previously reported.[1] The symptoms attributed to a particular case are those designated on submission cards accompanying the specimen to be analyzed. Annually 60% to 75% of all virus isolation specimens have been submitted by Milwaukee Children's Hospital.

The viral infections summarized in this paper were confirmed by serology, virus isolation, or both. Serological tests also have been carried out as previously described[1] using either a microcomplement-fixation procedure[2] or a microhemagglutination-inhibition procedure[3] to detect antibody to various viral antigens. For isolation of viruses, African green monkey kidney primary cells, human diploid cells (Wi-38 or M-7), and HEp-2 cells have been used routinely; and for some specimens, especially urines, human foreskin cell cultures have been inoculated. During the winter of 1979-1980, Madin-Darby canine kidney cells were used for isolation of influenza type B viruses. During each influenza season, most throat swabs also were inoculated into embryonated hens' eggs. Criteria for identification of virus isolates were the type of cytopathic effect and the host range in cell culture as well as serological procedures previously described.[1]

Results. The results reported in this study represent 3,254 isolates from 21,222 specimens (15.3% positive) and 1,918 serological confirmations of viral infections from 9,803 cases (19.6% positive). Basic background information that is useful for interpreting these results is presented in Figure 1. As shown, there has been a progressive increase in specimens submitted for virus isolation since 1975. Also two major seasonal peaks of specimen submission are apparent, one in the winter and another in the summer. It should be noted that peaks in the number of specimens submitted for patients with respiratory disease and the percentage of cases handled each month that are respiratory disease cases coincide with the winter peak in specimen submission for virus isolation. It is also evident that central nervous system (CNS) disease cases worked on each month are at a maximum during the summer peak in specimen submission for virus isolation. From Figure 1 it can be concluded that there are two major seasons of specimen submission for virus isolation—one in the winter associated with increased respiratory illness and one in the summer associated with an increase in the number of CNS disease cases.

The summer CNS disease peak. Typically we have well defined peaks in the isolation of nonpolio enteroviruses that are coincident with the summer CNS disease (usually aseptic meningitis) case peak (Figure 2). The month with the most confirmed cases has usually been August or September. The increasing height of the annual enterovirus isolation peaks through 1979 does not necessarily indicate that larger outbreaks of enteroviruses have occurred recently but more likely reflects an increased interest in submitting specimens for virus isolation.

Each summer a number of enteroviruses are present in the community but a few predominate. For example in the summer of 1979, 18 different nonpolio enteroviruses were identified, but Echo-11 was the predominant enterovirus, accounting for 40% of all confirmed enterovirus infections. Echo-7 was the second most commonly isolated enterovirus, accounting for 28% of confirmed infections. The

From the Milwaukee Health Department. Doctor Sedmak, Mr Abel, and Ms Voight are Virologists and Doctor Wisniewski is Director of Laboratories. Publication support provided. Reprint requests to: Gerald V Sedmak, PhD, Virus Laboratory, Milwaukee Health Department, 841 N Broadway St, Milwaukee, Wis 53202 (phone: 414/278-3526). Copyright 1981 by the State Medical Society of Wisconsin.

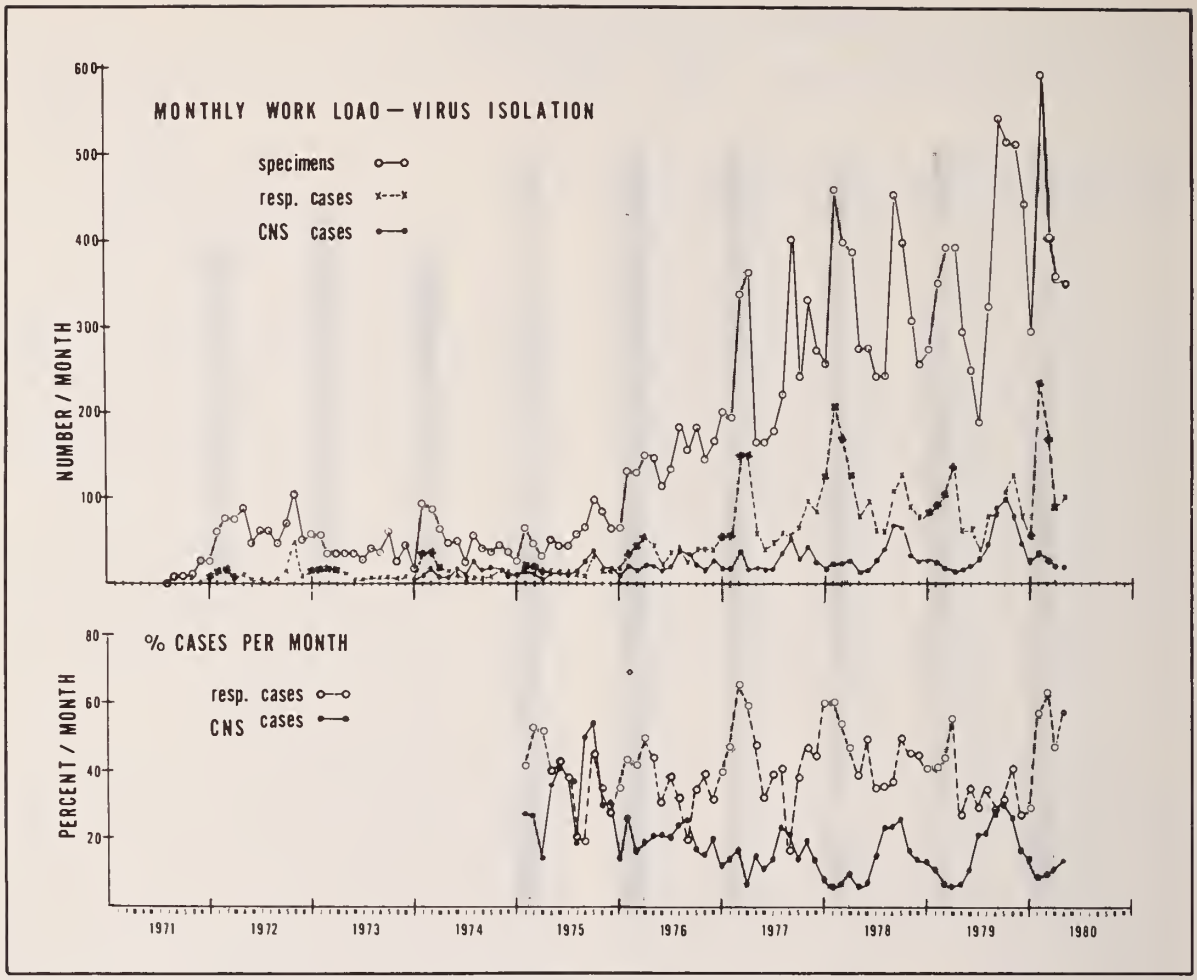

Figure 1—Seasonal fluctuation of the number of specimens submitted for virus isolation and the types of cases studied.

predominating strain varies from year to year.

Each summer the majority of the enteroviruses were isolated from specimens submitted for children between one and ten years of age. However, in 1979, 68% of the isolates were obtained from children under 12 months of age.

Since 1977, between 36% and 47% of the confirmed enterovirus infections each year were for persons with CNS disease. During this time span, 66 enteroviruses also were isolated from cerebrospinal fluids (17 cases Echo-11, 13 cases Echo-9, 10 cases Echo-7, 7 cases Echo-6, 7 cases Echo-30, 4 cases Echo-4, 3 cases Coxsackie A9, 2 cases Coxsackie B5, and 1 case each for Echo-14, Echo-16, and Coxsackie B4). This high occurrence of CNS disease in confirmed enterovirus infections, the coincidence of CNS disease and enterovirus peaks, and the lack of any major arbovirus activity in the Milwaukee area since 1977 implicate the enteroviruses as the major etiologic agents for CNS disease in the summers for Milwaukee.

We also have attempted to diagnose enterovirus infections using serologic techniques. To this end we have run complement fixation (CF) tests on serum pairs, using a Coxsackie B1 or B4 antigen. No type specific diagnosis can be obtained using this CF test but our results and previously published data[4,5] indicate that because of a heterotypic antibody response to the Coxsackie B antigens a diagnosis of enterovirus infection can be achieved. For example we obtained a four-fold or greater rise in CF antibody to these antigens for patients from whom we isolated Echovirus types 4, 7, 11, and 30. Enterovirus infections confirmed in this manner occurred at the same time that enteroviruses were isolated (Figure 2).

The winter respiratory illness peak. What occurs during the winter peak of respiratory illness is shown in Figure 3. The annual occurrence of influenza viruses in the community has a temporal coincidence with both the respiratory illness peaks and the winter workload peaks of Figure 1. As shown, influenza virus types A or B have been detected in Milwaukee every winter since 1967. The outbreaks peak in December, January, or February and a different strain is prevalent each year. Since 1971, the pattern of occurrence of influenza viruses has been an

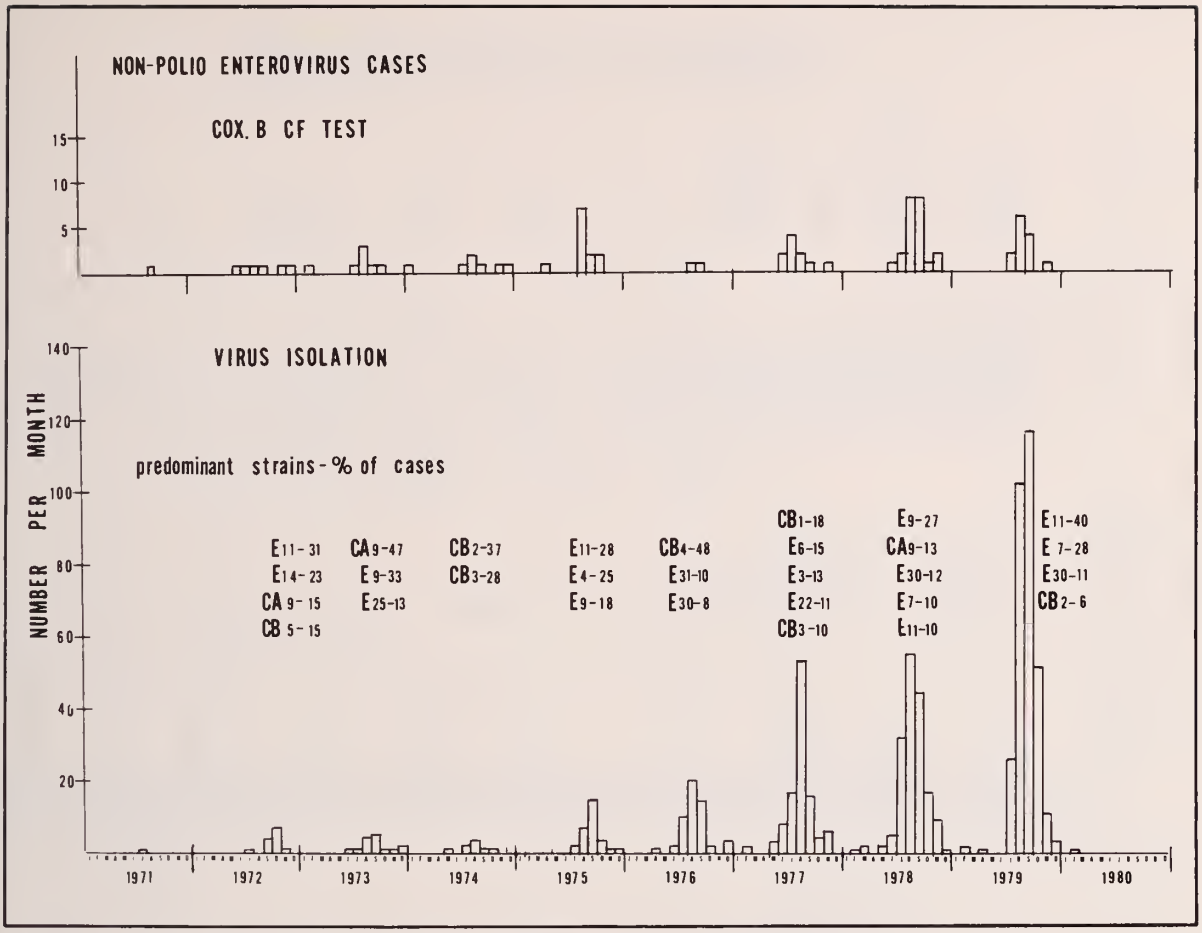

Figure 2—Confirmed nonpolio enterovirus infections.

influenza type B year, followed by two influenza type A years, then another influenza type B year. Again the number of confirmed cases is not indicative of the extent of an outbreak but more likely reflects specimen submission interest and varying sensitivity of our test procedures to detect an infection for different influenza strains.

For many sections of the country influenza type A outbreaks are associated with a general increase in pneumonia-influenza (PI) mortality or excess PI deaths[6] and Figure 3 indicates that this pattern also holds for the Milwaukee area. The number of PI deaths per month indicated are those that have been tabulated specifically for the City of Milwaukee. This information was obtained from the mortality data published in the annual report of the Milwaukee Health Department, Division of Vital Statistics, using international list numbers 470 to 486.

Although no baseline for expected PI deaths per month was calculated, a comparison of the upper and lower sections of Figure 3 indicates that in general increases in PI deaths per month coincide with influenza virus type A outbreaks and to a lesser extent with influenza virus type B outbreaks. The number of reported PI deaths per month associated with influenza outbreaks has been very low since the winter of 1976-77. No PI mortality increases were seen in association with a mild influenza virus type B outbreak in 1977 and the influenza virus type A/Brazil/H1N1 outbreak of 1979. A lesser peak of PI mortality was seen in the winter of 1977-78 even though three influenza type A strains were present in the Milwaukee community. In 1977-78 Milwaukee experienced a large outbreak of Russian influenza (influenza virus type A/USSR/H1N1) following an outbreak of two influenza virus type A/H3N2 strains. Although the Russian influenza outbreak was extensive (unpublished data—60% of Marquette University students infected) most persons infected were under 25 years of age and the associated PI mortality was therefore low. PI mortality data for 1980 were not available at the time this report was written but nationwide there was a greater than expected number of PI deaths associated with the influenza virus type B outbreak.[7]

Occurrence of other important viral respiratory pathogens. Our experience with other viral respiratory pathogens is summarized in Figure 4. Although the agents presented are important respiratory pathogens they do not have as great an impact on our workload as do the influenza viruses and the enteroviruses. The lesser impact of these agents on

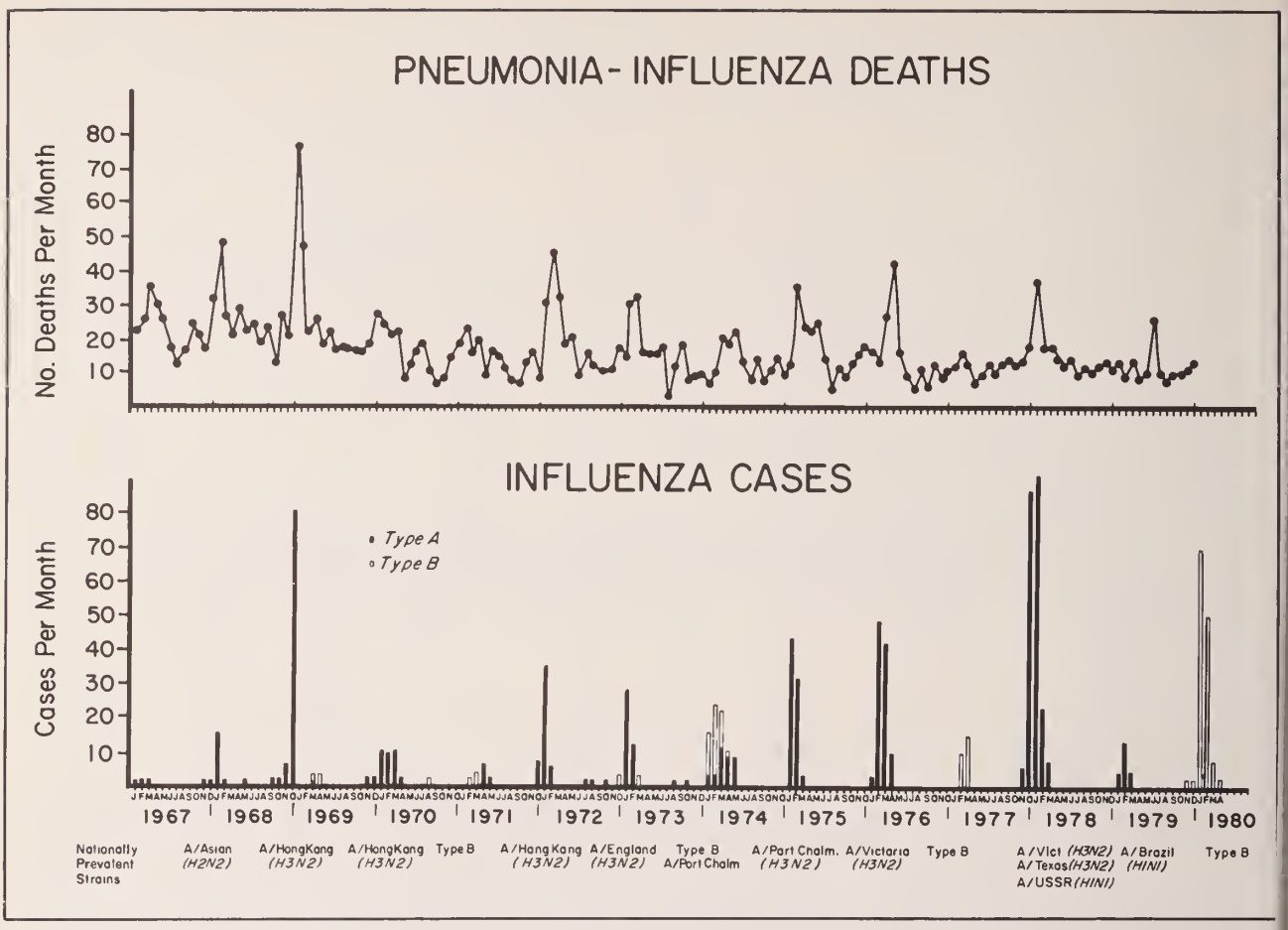

Figure 3—Comparison of influenza occurrence with peaks of pneumonia—influenza mortality.

our workload probably indicates their lesser impact on serious disease in the community.

Over the past decade respiratory syncytial virus (RSV) outbreaks have occurred regularly with recent outbreaks peaking in March. The RSV outbreaks are well-defined occurring primarily from January through April. A vast majority of the confirmed RSV cases in 1978 and 1979 were documented for children under 12 months of age.

Adenoviruses appear to be endemic in the population with an occasional outbreak. For the most part the isolates that have been typed have been type 1, 2, 3, 5 or 7 (typing done by the Wisconsin State Laboratory of Hygiene-Virus Section).

Although data are still sparse, the parainfluenza viruses, especially type 3, also appear to have an endemic pattern. At intervals outbreaks of type 1 and type 2 also occur but not in the same year. Further documentation of parainfluenza virus activity is necessary before clear patterns of occurrence can be detected.

As previously described[6] *Mycoplasma pneumoniae* also is endemic with an increase in confirmed infections in the fall of recent years. For our laboratory, *M. pneumoniae* was the second most common serologically detected respiratory infection second only to influenza virus type A. The greatest number of infections was confirmed for the 10-20 year age group.

Rhinovirus infections were not frequently detected with our routine diagnostic tests because persons with typical mild rhinovirus infections did not present themselves at hospitals to have specimens taken. Most of the confirmed cases were for college students at Marquette University. We have an ongoing respiratory surveillance program with Marquette University where mild respiratory illness caused by rhinovirus is studied. In 1977 and 1978 we detected spring and fall outbreaks of rhinoviruses. Little rhinovirus activity was detected at the University in 1979.

Summary. As our workload increased from 1975 to 1980 we have obtained more significant data as to when various viruses occur in the Milwaukee area. The presence of two groups of viruses in the community, influenza viruses and enteroviruses have a major impact on our workload. Influenza virus outbreaks occur every winter and enterovirus outbreaks every summer. Respiratory symptoms are associated with the influenza virus outbreaks and a large number of enterovirus infections are confirmed for persons with CNS disease.

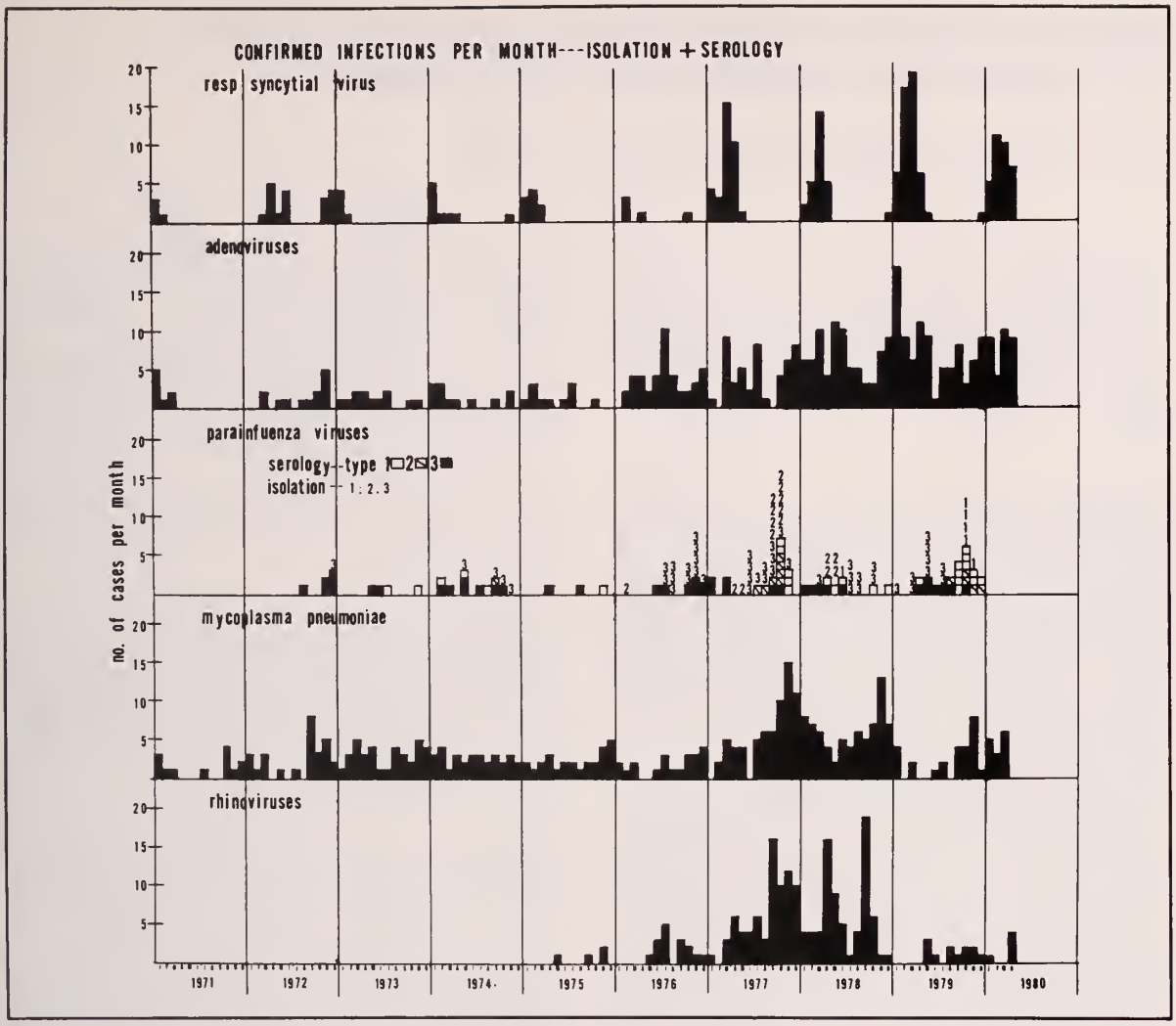

Figure 4—Seasonal occurrence of respiratory pathogens.

We have accumulated enough information on some other viruses to predict their seasonal occurrence in the Milwaukee area. We can predict that RSV outbreaks will occur in the late winter and early spring of each year, that adenoviruses and *M. pneumoniae* are endemic. From time to time, substantial outbreaks of *M. pneumoniae* occur in the fall but the timing of these outbreaks still has to be elucidated. More information about parainfluenza virus infections is needed to generate any long-range predictions for outbreaks but parainfluenza virus type 3 appears to be endemic at a low level.

ACKNOWLEDGMENT: The authors wish to thank Dr Harold Dobbs, Marquette University Student Health Service, for his continued interest in studying respiratory infections of college students, and Milwaukee area physicians for interest in studying viral infections.

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Supraclavicular central nervous catheterization: Technique and experience in 250 cases

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The technique of supraclavicular central venous catheterization is based on puncture, from above the clavicle, of the internal jugular-subclavian venous confluence, and has several useful applications. The procedure is described and recommended because of its ease, dependability, and safety.

IN RECENT YEARS central venous catheterization has become increasingly popular in the management of critically ill patients. Among the various techniques of catheter insertion are cutdowns over peripheral veins, and percutaneous approaches directly into the great veins via the infraclavicular, internal jugular, and supraclavicular routes. The latter technique, in which the junction of internal jugular and subclavian veins is entered from above and behind the clavicle,[1-4] has become the method of choice on our surgical services because of its ease of performance, reliability, and safety.

Our current consecutive series includes supraclavicular central venous catheterization in 250 cases, all under the authors' supervision, at the University of Wisconsin Clinical Sciences Center. Most of these patients were on general surgery, trauma, or cardiothoracic services, although some were medical and pediatrics patients seen in consultation. After our initial evaluation of the technique several years ago, indications for catheterization have been expanded to establishment of a reliable infusion line for fluid or blood, hyperalimentation, monitoring of central venous or pulmonary artery pressures, and rapid insertion of cardiac pacing electrodes. All patients had subsequent chest x-ray films, including those with supraclavicular punctures during cardiopulmonary resuscitation.

Method. The object of the supraclavicular technique is to puncture the skin in the angle formed by the clavicle and lateral border of the sternocleidomastoid muscle, and to enter the "sling" formed by the junction of the internal jugular and subclavian veins behind the sternoclavicular joint. Anatomically this is a safe approch, as the needle traverses an avascular fascial plane to the site of venipuncture; the dome of the pleura lies posterolaterally, and the subclavian artery lies deeper and relatively protected behind the anterior scalene muscle. We have seen no instance of trauma to the major lymphatic trunks by this approach.

The subject is placed in Trendelenberg position and sterile prepping and draping performed. It is much more tolerable for the patient for all materials to be assembled, opened, and readied before he is positioned and prepped, and since all maneuvers are performed in the posterior triangle of the neck, it has been our preference not to cover the face. The sterile field, however, should be wide enough to allow immediate change to a different technique (*ie,* internal jugular or infraclavicular) should the supraclavicular approach be unsuccessful.

The head is turned to the opposite side and the angle between the lateral border of sternocleidomastoid muscle and clavicle delineated; local anesthetic is usually necessary only for the skin. Puncture is then performed with a large bore needle and attached syringe, aiming just caudad to the contralateral nipple and entering just beneath the sternocleidomastoid muscle (Figures 1 & 2). (The preliminary use of a thin "pilot needle" to find the vein has been discarded, as this does not appear to insure either the safety or success of the technique.) Although emphasis has been placed on keeping the syringe behind the horizontal (coronal) plane with the patient supine,[4] it is often necessary to individualize the approach; if the vein is not entered with a full pass of the needle, it is withdrawn to a subcutaneous position and the depth and angle of insertion are successively increased. Venipuncture in adults is generally successful at a depth of approximately 4 cm and with the back of the syringe slightly above the horizontal.

As most situations involve catheterization for intravenous fluid and blood administration, hyperalimentation, or CVP monitoring, our preference is a sterile Intracath unit, with 14-gauge, 5-cm needle, and 16-gauge catheter tailored to the appropriate length. After the syringe is removed and the catheter is inserted, the needle is withdrawn and the assembly positioned for suturing. Blood must once again be aspirated through the catheter before any fluid is infused. To prevent pivoting or kinking, the assembly is secured in the supraclavicular region using a two-suture technique, and a simple occlusive dressing is applied.

Alternatively two other uses are possible. By employing a larger bore needle (*eg,* 10-gauge Medicut cannula; 8-F Edwards catheter introducer) or Seldinger wire set (*eg,* UMI percutaneous catheter introducer), a temporary pacing wire may be in-

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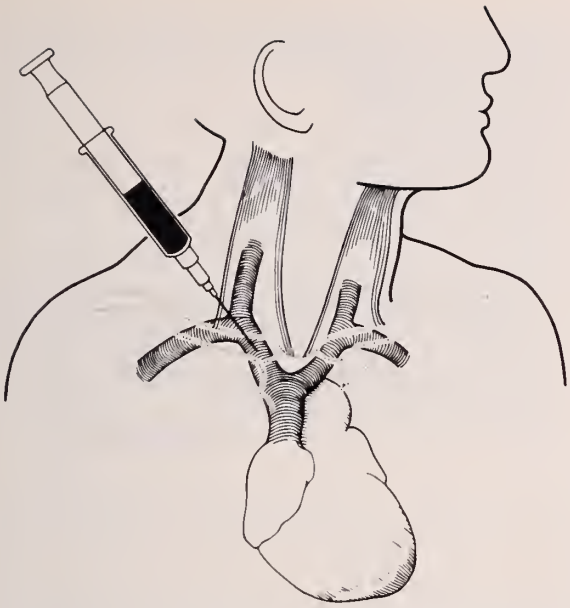

Figure 1—Coronal view of supraclavicular venipuncture. The needle enters the skin in the angle between clavicle and lateral border of the sternocleidomastoid muscle, with venipuncture of the jugular-subclavian venous confluence.

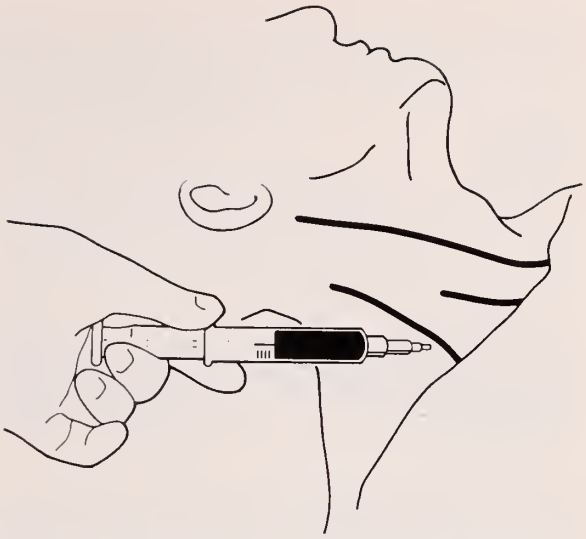

Figure 2—Operator's view of external anatomy. The needle is directed just caudad to the contralateral nipple, entering just beneath the sternocleidomastoid muscle, and is advanced until venous blood is aspirated.

serted into the right ventricle, or a Swan-Ganz catheter may be floated into the pulmonary artery, both with ease and rapidity.

Results. Experience with the supraclavicular approach in 250 instances is summarized in Table 1. It is noteworthy that successful venipuncture and a correctly positioned catheter was achieved in 95% of the cases, with a complication rate of 1.2%, including two pneumothoraces and one arterial puncture.

Table 1—Supraclavicular central venous catheterization

Total cases		250
Successful venipuncture	250	(100%)
Inability to thread catheter/wire	10	
Malposition	3	
Satisfactory placement	237	(95%)
Complications	3	(1.2%)

Discussion. Long peripheral lines and internal jugular and infraclavicular catheters have become increasingly less popular at our center during the past several years. Malposition of long antecubital lines is a frequent occurrence, with only 48-64% being in the innominate vein or superior vena cava radiologically.[5-6] Although encouraging results have been demonstrated for the internal jugular technique,[7-8] our objections to this approach include the tendency to hematoma formation in the loose tissues of the neck, a relatively insecure catheter owing to head motion, and rare but potentially catastrophic sequelae if carotid puncture should occur. The widely used infraclavicular subclavian approach,[9] on the other hand, is probably the most difficult to master and perform safely, as external anatomy may be vague, and the space between clavicle and first rib is often inaccessible due to osteophytes or calcification. In one often-quoted large series,[10] for example, there was a 24% failure rate and 8% malposition rate by this technique.

The outstanding advantage of the supraclavicular technique, on the other hand, is its dependability. Except in occasional situations in which the subject is unable to turn the head, such as cervical trauma or severe arthritis, it is applicable to essentially all patients, including small children. The technique is readily learned, as the important external anatomic landmarks are well-defined, and the jugular-subclavian venous confluence provides a large target for puncture. This is confirmed by the 100% successful venipuncture rate in the present series, and that of 95-100% by other authors[1,2,4,11] Correct positioning of the catheter is extremely reliable in the supraclavicular approach as well, with a combined inability to thread the catheter and malposition rate of only 5% in our 250 cases, 2% of 130 patients studied by Yoffa,[4] and no malpositions in the 83 cases of Garcia et al.[1]

In terms of safety supraclavicular catheterization is at least comparable to the infraclavicular approach. Borja,[9] for example, found a complication rate of 0.4-10% in his extensive review of the literature on infraclavicular placement. In five series on the supraclavicular approach,[1,2,3,4,11] on the other hand, this rate was 0-6%, including no compli-

cations among Yoffa's 130 cases,[4] and none among 200 cases by Nugent.[3] Our complication rate of 1.2% in 250 instances is consistent with such reports, and there have been no serious long-term sequelae.

Although no single technique can be considered a panacea for central venous catheterization, we have been quite satisfied with the supraclavicular approach in terms of its ease, reliability, and safety.

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Abstracts

Thyroid carcinoma following treatment for acute lymphoblastic leukemia

THOMAS T TANG, MD, PhD; JOHN S HOLCENBERG, MD; STEPHEN C DUCK, MD; ALBERTINA E HODACH, PhD; HERBERT W OECHLER, MD; and BRUCE M CAMITTA, MD, Milwaukee Children's Hospital, Medical College of Wisconsin, and Midwest Children's Cancer Center, Milwaukee, Wis:

Cancer 46:1572-1576, 1980

A 2½-year-old girl with acute lymphoblastic leukemia received chemotherapy and prophylactic cranial irradiation. After six years of remission, including three years off therapy, metastatic thyroid carcinoma appeared in the cervical lymph nodes. The predisposing factors for the development of thyroid carcinoma as a second malignancy in this case were discussed. It was suggested that thyroid carcinoma should be added to the growing list of second malignancies in acute lymphoblastic leukemia and that careful thyroid examination be included in the follow-up of long-term survivors. ■

Incidental appendectomy in the elderly? No

STEVEN R NOCKERTS, MS; DON E DETMER, MD; and DENNIS G FRYBACK, PhD, Wisconsin Professional Review Organization, Inc and the Departments of Preventive Medicine, Surgery, and Industrial Engineering, University of Wisconsin, Madison, Wis:

Surgery 88:301-306 (Aug) 1980

The appropriateness of incidental appendectomy in the elderly was examined by studying the incidence of appendicitis and incidental appendectomy in 1977 in those 65 or older in Wisconsin. The 1977 incidences of needed appendectomies and incidental appendectomies in citizens 65 or older were 0.78 and 1.59 per 1000 population at risk, respectively. During 1977, 3.73 people were spared an appendectomy during their remaining life because 382 incidental procedures had been performed. Over 100 incidental procedures were necessary to avoid a single case of appendicitis. At the 1977-78 mortality rate of 3.5% for appendicitis in patients 65 or older, nearly 3000 incidental procedures would have to be performed without causing a death in order to save a life that would have otherwise been lost to appendicitis. It is doubtful that incidental appendectomy in the elderly can improve this threshold of risk. The procedure would possibly be slightly cost beneficial. Therefore, incidental appendectomy is not indicated in the elderly, since the risk of incidental appendectomy would probably outweigh its potential benefits. ■

Choledochoduodenostomy: Importance of common duct size and occurrence of cholangitis

MATHEW A KRAUS, MD and STUART D WILSON, MD Medical College of Wisconsin, Milwaukee, Wis:

Arch Surg 115:1212-1213 (Oct) 1980

Choledochoduodenostomy was performed in 68 patients. In these cases we attempted to determine any correlation between the size of the common duct and subsequent cholangitis. Followup information was available in 64 (94%) of the cases, with a mean followup of three years. The most common indication for choledochoduodenostomy was choledocholithiasis. Prior biliary surgery was used in 33 (48%) patients. Benign disease was present in 51 patients, and 17 patients had malignant neoplasms. The mean size of the common duct was 2.1 cm and the range was 1.0 to 4.0 cm. Only two patients (2.8%) experienced episodes of cholangitis after choledochoduodenostomy and both of these patients had a common duct that measured less than 1.6 cm at the time of anastomosis. Other procedures than choledochoduodenostomy should be considered when common duct size is less than 1.6 cm. ■

Perinatology
Editor: LUIS B CURET, MD
Professor, Department of Obstetrics and Gynecology
University of Wisconsin Center for Health Sciences
Madison General Hospital, Madison, Wisconsin

Neonatal polycythemia and the hyperviscosity syndrome

David N Sheftel, MD, Madison, Wisconsin

EDITORIAL NOTE: It is well recognized the neonatal polycythemia can be a major contributor to perinatal morbidity and long-term developmental disabilities. The accompanying article summarizes the present state of knowledge of the condition and suggests guidelines for its treatment.—LBC

Approximately 4-5%[1] of all newborn infants (2,000-3,000 in Wisconsin each year) have a venous hematocrit which is greater than 65%. The majority of these infants are full term and appropriate for gestational age. All of these newborns will have hyperviscous or "thick" blood, as will a few babies with venous hematocrits which are greater than 60% but less than 65%. Because of their hyperviscous blood, many will have complications such as seizures, respiratory distress, necrotizing enterocolitis, and renal vein thrombosis in the neonatal period and are at a risk for subsequent developmental delay and cerebral palsy.

The three determinants of whole blood viscosity are the hematocrit, the deformability of the red blood cells, and the plasma viscosity. The hematocrit is by far the most important, and with small changes in hematocrit above 65%, the viscosity increases dramatically. Yet, some newborns with hematocrits between 60% and 65% also have hyperviscous blood. These newborns may have red blood cells whose deformability is intrinsically abnormal or is affected by hypothermia, acidosis, or hypoxia.[2] Also, these infants may have elevated plasma viscosity caused in part by increased fibrinogen and other plasma proteins.[3]

Symptoms are usually not present at birth but develop during the first 24 hours of life when the hematocrit rises secondary to the mobilization of excess fluid in the normal newborn. It is very unusual for symptoms to first develop after 48 hours of age. Symptoms generally reflect a compromised cardiopulmonary or central nervous system. Cyanosis, plethora, tachycardia, hepatomegaly, tachypnea, and respiratory distress are common and because of this, these infants have often been suspected initially as having congenital heart disease[4] or transient tachypnea of the newborn.[5] Symptoms involving the central nervous system can be as subtle as feeding difficulties, poor suck, and lethargy, or as obvious as generalized seizures, jitteriness, extreme irritability, and hyper or hypotonia.

In the majority of neonates with polycythemia it is difficult to assign a specific etiology, although it clearly occurs in a number of clinical settings. The most common is a placental transfusion of red blood cells. Delayed clamping of the umbilical cord may increase the postnatal blood volume by as much as 60%,[6] 50-70% of which is transfused within one minute of birth.[7] The same process can take place in a twin pregnancy with a fetal-fetal transfusion, in which the morbidity and mortality are as high in the polycythemic twin as the anemic twin.[8] The newborn can also receive a transfusion of maternal red blood cells across the placenta[9] during labor and delivery. Conditions associated with placental insufficiency and intrauterine hypoxia might also produce polycythemia, presumably as a result of increased erythropoietin production. This accounts for the increased incidence seen in small-for-gestational-age infants and in post mature infants.[10] Polycythemia with hyperviscosity is also associated with maternal diabetes, congenital adrenal hyperplasia, neonatal thyrotoxicosis, trisomy 21, and Beckwith's syndrome.

The pathophysiology of this syndrome is summarized in Figure 1. The newborn becomes polycythemic because of a perinatal transfusion which increases blood volume or as a result of intrauterine hypoxia which increases erythropoietin production. This polycythemia results in a plethoric appearance, hyperbilirubinemia (because of increased red blood cells) and hyperviscosity. Altered plasma proteins and increased red blood cell rigidity contribute to the hyperviscosity. The result of the hyperviscous blood is an increase in peripheral and pulmonary vascular resistance with right to left shunting of blood through a patent ductous arteriosis or foramen ovale with resultant cyanosis. The infant also has a low cardiac output which might be worsened by as-

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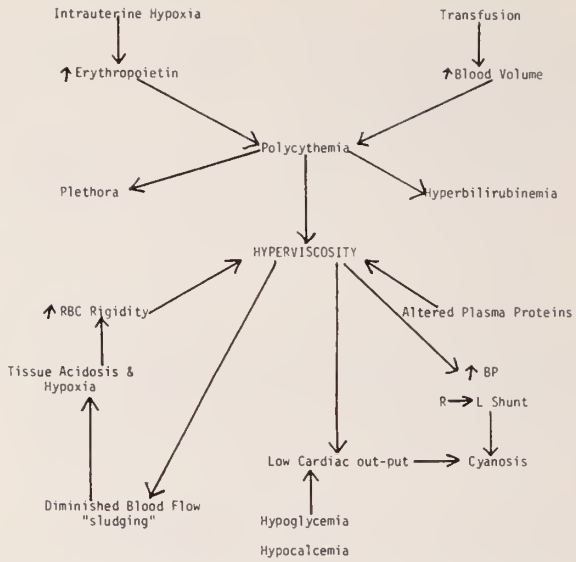

Figure 1—Summary of the pathophysiology of the neonatal polycythemia and hyperviscosity syndrome.

sociated hypoglycemia and hypocalcemia. Other systems become involved as the hyperviscous blood "sludges" within the capillaries and compromises oxygen transport to the tissues.

At the present time treatment consists of a partial exchange transfusion through an umbilical vein catheter using fresh frozen plasma. The attempt is to lower the hematocrit to 50-55%. The amount to be exchanged can be easily calculated using the formula:

$$\text{Volume of exchange} = \frac{\text{Kg x 80 cc/kg x (Hcto-Hctd)}}{\text{Hcto}}$$

where kg equals the weight in kilograms, Hcto equals the observed hematocrit and Hctd equals the desired hematocrit. Currently, all newborns who have a venous hematocrit of greater than 65% or whose hematocrit is between 60 and 65% and whose blood viscosity is elevated, should be observed closely for symptoms. If symptoms are apparent, these babies should receive a partial plasma exchange transfusion. At the present time it is unclear what should be done with the neonates who have an elevated hematocrit or whole blood viscosity but who are not symptomatic.

In long-term follow-up, it appears that children who had the hyperviscosity syndrome in the neonatal period have a high incidence of developmental delay, including fine motor and speech abnormalities, and spastic diplegia. The incidence of developmental delay is highest[11] in the newborns who received a partial exchange transfusion. Most likely this reflects the fact that partial plasma exchange transfusions are generally done on the most symptomatic newborns in whom a significant amount of central nervous system damage has already taken place. This raises the question as to whether neonates who have an elevated hematocrit or whole blood viscosity and are asymptomatic should receive a partial plasma exchange transfusion. Early partial plasma exchange transfusion would treat the polycythemia before irreversible damage takes place.

In summary, polycythemia causing hyperviscosity is a relatively frequent occurrence in the newborn who is generally considered at low risk for other neonatal problems. Therefore, those individuals who work with the healthy term newborn should be aware of this potential problem and develop a high index of suspicion when confronted with a newborn who is exhibiting subtle symptoms of hyperviscosity. Possibly through early identification and treatment many of the subsequent disabilities can be prevented.

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SMS representatives meet with Governor

Governor Dreyfus ran a couple of ideas up the public health flagpole during a late 1980 meeting with SMS President Russell Lewis, MD, President-elect Albert Motzel, MD, Secretary Thayer, Kermit Newcomer, MD, LaCrosse, and Robert Carlovsky, MD, Fond du Lac, chairmen, respectively, of ad hoc study committees on Physician Distribution and the Public Health System in Wisconsin.

On physician distribution the Governor expressed interest in the Society's proposal for a substantial overhaul of National Health Service Corps' operations in Wisconsin. He asked for SMS support in advising him on current problems with NHSC regulations and suggestions for change.

In supporting the student assistance loan program, the Governor suggested that as many as ten places in each medical school's incoming class be "reserved" for students willing to practice in Wisconsin underserved areas for a period of 5-7 years in exchange for a total state payment of the out-of-pocket costs of medical education, currently estimated at as much as $50,000.

On the public health side, the Governor was pessimistic about any state revenue sharing for support of local public health programs. Instead, he suggested that government regulation and tax support for public health programs such as water purity, restaurant and food inspection, swimming pool and other local sanitation problems, be eliminated in favor of private business-supported "good housekeeping seal" programs to assure the public's protection against disease and other public health hazards. He suggested that when such programs fail, the individual member of the public should seek appropriate penalties or other remedy through liability litigation.

The SMS delegation expressed concern that his proposal represented an abandonment of both publicly and medically acceptable health protection principles. They seriously questioned whether the application of the motorcycle helmet philosophy (individual responsibility) could be applied to areas of broad public health concern.

SMS proposes to move ahead with already approved plans to support a more integrated public health system. ■

AMA House of Delegates action

At its 1980 Interim Meeting in December, the American Medical Association's House of Delegates voted to seek repeal of health planning and Professional Standards Review Organization (PSRO) legislation.

In addition to calling for cessation of funding and the introduction of repeal legislation in the 97th Congress, the action on health planning laws PL 93-641 and PL 96-79 calls for the AMA to develop principles for a voluntary, locally based health program. It further asks the medical profession to "accept responsibility and assume a position of leadership" in solving problems posed by "state and regional attitudes and directives."

In its statement seeking the elimination of all government-directed peer review programs including PSRO, the House said the AMA's policy would be "to continue professionally directed efforts to ensure that care provided to patients is of high quality, appropriate duration, and is rendered in an appropriate setting or at a reasonable cost.

Other actions of the House:

- Urged state and county medical societies to embark on "corporate visitation" programs as a means of assisting the business and industrial community during a period of rising health costs.
- Asked private sector insurance companies to provide reimbursement for medical and surgical procedures that can be performed safely in outpatient settings as a means of containing health care costs.
- Stressed the need for ready access to computer tomographic scanners.
- Called for development of a uniform method for evaluating the qualifications of graduates of foreign medical schools, taking the position that the mechanism should be based in the private sector and that the standards should be equivalent to those by which US schools are evaluated.
- Called for a formal membership promotion program at all levels of the AMA federation. ■

Book discount program effective

Since the Book Discount Program was started last April, members have used it to purchase over $5,000 of books and have saved themselves more than $550 in discounts. Members interested in the program should contact SMS Services, Inc, PO Box 1109, Madison, Wis 53701; or call 257-6781 or toll-free 1-800-362-9080. ■

SMS annuity unit value $4.10

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $4.10 as of November 28, 1980. This compares with $3.68 as of October 31 and $3.57 at September 30. ■

PA field consultant selected

On February 2 Ms Kris Bjurstrom joined the Physicians Alliance staff as a field consultant in District 3.

Ms Bjurstrom, 30, is a graduate of UW-Madison and has a number of years of experience in community organization and worked as a volunteer in several political campaigns. She is based out of Oshkosh.

District 3 includes the following counties: Brown, Calumet, Dodge, Door, Fond du Lac, Kewaunee, Manitowoc, Marinette (southern half), Oconto (southeast), Outagamie, Sheboygan, Waupaca, and Winnebago.

The position has been vacant since last fall following the resignation of Cal Dexter who entered law school. ■

Health Planning conference February 27-28

New directions in regulation in light of the changing administration is the topic of this year's State Medical Society of Wisconsin-Wisconsin Hospital Association Conference on Health Planning.

The February 27-28, 1981 meeting at the Lake Geneva Playboy Club will feature Colin Rorrie, PhD, director of the Bureau of Health Planning, US Dept of Health and Human Services. Doctor Rorrie will address the physician and hospital CEO group from a federal agency perspective.

John Tillotson, MD, vice president of InterStudy, will discuss health delivery reform legislation. Doctor Tillotson has served as a legislative health aide to Senator David Durenberger (R-Minn) and drafted S 1968, the Health Incentives Reform Act.

The luncheon address by John Iglehart, director of the Washington Office of the Washington, DC office of the Kaiser Foundation Health Plan will look at the Reagan administration's first month in office and speculate on the future of healthcare regulation under it.

On a state level, Terry Willkom, acting director, Wisconsin Division of Health, will brief attendees on new activity in the Wisconsin Dept of Health and Social Services. In addition, several discussion groups have been scheduled throughout the conference to address competitive alternatives to state and federal regulation.

Scientific programming on Saturday, February 28, will feature a presentation on "A Practical Approach to Quality Assurance" by Doctors Thomas Dehn, Milwaukee, and Philip Utz, LaCrosse, and Dr John R Payne of the Joint Commission on Accreditation of Hospitals.

Continuing Medical Education credit will be available.

Further details regarding this conference were included in a special membership mailing. ■

Named director of rate review

Doug Nelson, a member of the SMS staff for six years, has resigned to become director of the Wisconsin Hospital Rate Review Program. The program is funded on a voluntary arrangement by the State of Wisconsin, the Wisconsin Hospital Association, and Blue Cross/ Blue Shield United. The program staff to be headed by Nelson works out of Blue Cross offices in Milwaukee. During his years with SMS, Nelson served as a legislative coordinator and director of the Society's Health Services Division. ■

WHCLIP's tax-exempt status questioned

The Wisconsin Health Care Liability Insurance Plan (WHCLIP) recently received an adverse ruling from the Internal Revenue Service on the validity of its tax-exempt status. WHCLIP currently provides medical liability insurance to approximately 55% of the state's physicians.

WHCLIP has contended that as a nonprofit agent of the state, it is exempt from paying state and federal income tax.

While the State Attorney General and even the regional IRS office have expressed agreement with this position, the Washington, DC office of the IRS has declared that WHCLIP is a taxable entity and is preparing an assessment to be submitted to WHCLIP around January 1, 1981. The potential tax liability is estimated at $11 million.

Upon receipt of the tax assessment, WHCLIP intends to file an appeal and challenge the IRS decision.

The Independent Insurance Agents of Wisconsin allege that the tax-exempt status gives WHCLIP an unfair advantage over commercial carriers and asked that the WHCLIP Board not appeal the IRS decision.

Fred Kriss, MD (Madison neurosurgeon and the State Medical Society representative on the WHCLIP Board of Governors) told the Board on December 10 that the major advantage of WHCLIP over commercial carriers is WHCLIP's policy of not denying or cancelling coverage of any physician because of that physician's specialty or past experience.

Doctor Kriss reminded the Board that it was the commercial market's refusal to provide coverage to high risk and newly licensed physicians that prompted the legislative creation of WHCLIP in 1975. ■

Scandinavian holiday offered

A unique holiday to the land of the midnight sun—Scandinavia—is now being offered to physicians and their friends through a special tour being arranged by the State Medical Society of Wisconsin and Dittmann Tours, Inc. The two-week tour, scheduled for June 27-July 11, will highlight the many faces of Scandinavia—the mountain and fjord scenery of Norway, the enchanting countryside of Denmark and Sweden's folklore rich provinces. Further details are contained in a tour brochure recently mailed to SMS physicians. ■

Physicians continue to volunteer treating Indo-Chinese refugees

Physicians throughout Wisconsin continue to respond to an SMS appeal last fall for providing medical care to Indo-Chinese refugees living in Wisconsin. Physicians who have responded include:

Frank Walker, MD, Wauwatosa
Roger S Gray, MD, Evansville
Geoffrey C Kloster, MD, Merrill
Michael J O'Halloran, MD, Eau Claire
William C Miller, MD, Wausau
James D Warrick, MD, Madison
N Neelagaru, MD, Neillsville
Conrad E Eastwold, MD, Rice Lake

The State Medical Society is appreciate of their concern. Other physicians interested in accepting Indo-Chinese patients should write: Indo-Chinese Care, PO Box 1109, Madison, Wis 53701. ■

State Medical Society of Wisconsin

House of Delegates—1981

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	Joyce A Yerex	Raymond W Witt
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	Vacancy	Vacancy
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DOOR-KEWAUNEE	John J Beck	Walter S Hobsor
MANITOWOC	David D Pfaffenbach	Edward J Baryla
	Gary A Schmidt	Steven D Drigger
MARINETTE-FLORENCE	Charles E Koepp	John E Kraus
OCONTO	Kenneth L Strebe	John S Honish
SHAWANO	Vacancy	John J Albright
SHEBOYGAN	Robert A Keller	Patrick R Marsh
	Stephen C Westcott	Vacancy
SEVENTH DISTRICT		
BARRON-WASHBURN-BURNETT	Donald E Riemer	James F Maser
CHIPPEWA	Merne W Asplund	John J Sazama
EAU CLAIRE-DUNN-PEPIN	Thomas E Pederson	Steven G Brown
	Karl E Walter	George E Owen
	James E Willard	John B Young
PIERCE-ST. CROIX	David M Woeste	Joseph E Powell
POLK	Marwood E Wegner	John O Simensta
RUSK	Raymond R Johnson	Richard G Nash
EIGHTH DISTRICT		
ASHLAND-BAYFIELD-IRON	A A Koeller	John C Oujiri
DOUGLAS	Clarence M Scott	Thomas J Doyle
SAWYER	Martin H Sahs	Vacancy

SPECIALTY SECTIONS

Section	Delegates	Alternates
Allergy & Clinical Immunology	Martin Z Fruchtman	John J Ouellette
Anesthesiology	Warren J Holtey	James J Brill
Dermatology	Joel E Taxman	Nyles R Eskritt
Emergency Medicine	Frederick A Klemm	Gary L Gerschke
Family Physicians	Robert F Purtell, Jr	John O Grade
Internal Medicine	Anthony P Ziebart	Michael J Mally
Medical Faculties	Mark J Ciccantelli	Manucher J Javic
Medical Students	William Armington	Timothy Roddy
Neurology	Michael P McQuillen	Vacancy
Neurosurgery	Werner E Langheim	Allan B Levin
Obstetrics-Gynecology	William E Martens	Robert P Reik
Ophthalmology	John L Sella	W James Foster
Orthopedics	Paul A Jacobs	Roger P Johnson
Otolaryngology	Thomas W Grossman	Glenn M Seager
Pathology	Edward A Burg, Jr	Robert E Carlovs
Pediatrics	Richard L Myers	William H Bartle
Physical Medicine & Rehabilitation	William J LaJoie	Sridhar V Vasud
Plastic Surgery	Vaughn Demergian	Vacancy
Preventive Medicine	Richard W Biek	Paul R Ebling
Psychiatry	William W Wood	Fred H Koenecke
Radiology	Loren E Hart	Bruce C Kirkham
Resident Physicians	Joseph Selliken, Jr	Colleen M Couni
Surgery	J David Lewis	Louis C Bernhard
Urology	[illegible]	[illegible]

Membership, second opinions key issues in resolutions

The House of Delegates will consider resolutions ranging in subject matter from membership and dues issues to second opinion programs and physician distribution and reimbursements in insurance programs at the State Medical Society's Annual Meeting in Milwaukee, March 26-28.

The following resolutions were received in the Secretary's office by the January 26 deadline. These will go to the House of Delegates for action during its three sessions at the MECCA in Milwaukee. Members are urged to express their opinions to their delegates (see page 44 for list) and to participate at the Annual Meeting Reference Committee hearings where resolutions are discussed.

Members are reminded that the issue of unified membership (yes or no) will be up for vote by the House when it acts on the proposed general revision of the Constitution and Bylaws introduced in the 1980 session for action in the 1981 session.

(The county medical society, individual physician, or specialty section which introduced the resolution appears in parentheses.)

1. (Columbia-Marquette-Adams) Unified Membership

"RESOLVED, that Article IV of the proposed general revision of the Constitution and Bylaws of the State Medical Society of Wisconsin, as introduced at the 1980 annual meeting for final action at the 1981 annual meeting, be amended to delete the words 'who shall also be members of the American Medical Association,' said Article IV then to read as follows:

"This Society shall consist of members who shall be the members of and certified by the component county medical societies; and whose dues and assessments for the current year have been received by the Society secretary in accordance with the schedule provided for in the Bylaws."

2. (LaCrosse) Unified Membership

"RESOLVED, that the House of Delegates is urged to adopt an amendment in Article IV of the SMS Constitution to be considered at the 1982 House of Delegates meeting that would delete from Article IV of the Constitution wording which mandates membership in the AMA, and such article then would read as follows:

"This Society shall consist of members who shall be the members of the component medical societies, ~~and who shall also be members in good standing of the American Medical Association, and~~ who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary."

Speaker's note: This resolution as submitted relates to the current wording of Article IV. The House should be aware that this Article has been slightly reworded in the proposed revision to be acted upon in March 1981. The resolution may require rewording to conform with House action on Article IV.

3. (LaCrosse) SMS Dues Structure

Because increasing the total number of members in county and state medical societies and in the AMA decreases the society's cost to any individual member; and the increasing numbers of women medical school graduates presages an increasing number of two physician nuclear families which frequently utilize one membership only; therefore be it

"RESOLVED, that the House of Delegates investigate alternative dues structures which would provide incentives for both physicians in such families to become members. As an example, we have the recommendation by the Council Membership Committee that consideration be given to the reduction of dues by cost of mailing to two members at one home address."

4. (Milwaukee County Delegation) SMS Dues Structure

"RESOLVED, that Chapter VIII, Section 1 of the SMS Bylaws be amended by adding the following paragraph:

"An active member in good standing in one's county society who has attained seventy (70) years of age shall be exempt from the payment of dues or assessments; and be it further

"RESOLVED, that the State Society urge its component county societies to adopt a similar policy, if they have not already done so."

Fiscal Note: Milwaukee County, with 28% of the State membership, has 45 members over age 70 still practicing at least 1,000 hours per year. Based on this ratio, it can be assumed that there are 125 SMS members statewide in this age category who are required to pay full SMS dues. Exemption from this obligation would reduce SMS dues by $47,500 to be made up from other sources.

Speaker's Note: This resolution relates to Chapter VIII of the current Bylaws. It should be considered in relation to Chapter I, Sections 9 and 10, of the proposed revision of the Constitution and Bylaws before the House for action in March 1981.

5. (Green) SMS Dues Structure

"RESOLVED, that the annual dues requirement be dropped for physicians reaching the age of 70."

6. (Kenosha) County Medical Society Presidents

"RESVOLED, that county medical societies be encouraged to advance by one year the election of their presidents so that each such person may serve in the capacity of president-elect for one year prior to assuming the responsibilities of president, thus being better able to carry out those duties to the advantage of the membership and the profession as a whole."

7. (Kenosha) County Medical Society Officers Conference

Because the State Medical Society's leadership conference is a useful and important means to provide those who attend with information on key issues facing the profession; and officers of county medical societies, especially newly elected presidents, presidents-elect and secretaries, have a need to discuss their special roles as officers and leaders, specific ways to carry our legislative, membership and public relations programs, and other practical aspects of identifying and using SMS medical leadership and staff resources to help operate effective county medical societies; therefore be it

"RESVOLED, that the State Medical Society annually organize a conference at the Society headquarters in Madison geared to the specific and practical needs of county medical society officers.

Fiscal Note: A. Costs of a luncheon for 50-100 @$4.00 = $200-$400; or B. Luncheon plus reimbursement of mileage for an additional $1,500-$3,000.

8. (Fond du Lac) Title 19 Second Opinion Program

Because it has been previously and adequately demonstrated that mandatory second opinions before elective surgery do not result in monetary savings, and often result in increased costs; and that second opinions before surgery do not result in a significant decrease in numbers of surgical procedures performed, nor in so-called "unnecessary" surgery; and the Wisconsin Title 19 second opinion program is so structured that it will result in varying degrees of hardship to many patients and is so structured that second opinions can be totally ignored and surgery performed despite contrary recommendations; and will serve to enlarge the bureaucracy, for purposes of marginal or undemonstrated benefit; and it is not only desirable but essential that the State of Wisconsin decrease, not increase, unrewarding bureaucratic expenditures; and it would appear that the present Title 19 mandatory second opinion program was conceived and legislated without sufficient consideration of any of the above factors as well as other pertinent factors; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin urge and support legislation to repeal legislation mandating a second opinion before surgery; and be it further

"RESOLVED, that the State Medical Society of Wisconsin conduct an active public service and information campaign to clearly demonstrate to the taxpaying citizens of this state the personal hardships, the medical and economic fallacies of this program."

9. (Milwaukee County Delegation) Title 19 Second Opinion Program

Because the Department of Health and Social Services has been directed by the State Legislature to establish a mandatory second opinion program for selected elective surgical procedures under the Title 19 Medical Assistance Program; and the implementation process adopted by DHSS has more than the usual amount of bureaucratic "red tape," placing unreasonable burdens on both the affected Medicaid recipients and their attending physicians; and recent studies, such as that conducted by Blue Cross of Greater New York, indicate that second opinion surgical programs may actually increase the number of surgeries performed and therefore increase medical care costs; therefore be it

"RESVOLED, that the State Medical Society wage a vigorous effort to have the State Legislature repeal this ill considered legislation; and be it further

"RESOLVED, that, in the meantime, State Medical Society representatives insist that DHSS take a more reasonable and responsible approach in its implementation of the mandatory second opinion surgical program."

10. (Juneau) Physician Distribution/ Reimbursement

Because the Wisconsin Comprehensive Health Plan has long recognized that "The present reimbursement structure of third-party payers is such that fees are lower for rural physicians. This created a financial disincentive for physicians to practice in rural areas, thus contributing to the current maldistribution of physicians," and in 1980 the House of Delegates of the State Medical Society of Wisconsin adopted the following resolution: "RESOLVED, that the State Medical Society of Wisconsin support a policy to establish fee structures throughout the state that are equitable and foster physician distribution," and therefore be it

"RESOLVED, that the House of Delegates of the State Medical Society of Wisconsin hereby authorize and direct the Council and the Physicians Alliance to obtain the needed waivers so that reimbursement from both Medicare and Medicaid shall be a single uniform fee for each procedure for all physicians within Wisconsin, based on the average amount paid for each procedure during a base year, updated to the present year, and regularly thereafter by applying the same methods used to update Social Security benefits."

11. (Section on Internal Medicine) Nursing Home Physician Visitation Frequency

"RESOLVED, that the State Medical Society of Wisconsin oppose mandatory designation for the number of physician visits to nursing home patients since there is no documentation of a cost/benefit improvement by present studies; and be it further

"RESOLVED, that personal physicians should be strongly encouraged to continue care for their patients admitted to nursing homes if practical and reasonable."

12. (Section on Internal Medicine) Equitable Risk Classification in Medical Liability Premiums

"RESOLVED, that the State Medical Society of Wisconsin support the concept that premiums for medical liability insurance should reflect the costs and risks of providing that insurance to each category insofar as feasible based on accepted underwriting principles."

13. (Milwaukee County Delegation) Wisconsin Health Care Liability Insurance Plan

Because 55% of Wisconsin physicians are now participants in the Wisconsin Health Care Liability Plan (WHCLIP); and it was established by the State Legislature, in collaboration with the State Medical Society, because several private carriers cancelled professional liability coverage which they had been providing to physicians in Wisconsin and elsewhere; and WHCLIP is a basically sound program and efforts are underway to make it even more successful; and because some private carriers which cancelled Wisconsin physician coverage are now attempting to re-enter the marketplace; therefore be it

"RESOLVED, that the State Medical Society remind its members of these historical facts and caution them to think carefully about transferring their WHCLIP professional liability protection to these carriers.

14. (Dane) IPA-HMO Programs in the State of Wisconsin

Because there is general concern that physicians are not knowledgeable enough regarding health care and its changing relationship with business, hospitals, government, and insurance companies who are in some instances trying to totally control health care quality, cost and methods of delivery; and it is the purpose of the State Medical Society of Wisconsin to maintain the principle of free choice of physicians by the patient and to make certain its members are fully informed on such issues; therefore be it

"RESOLVED, That the State Medical Society of Wisconsin accumulate information concerning IPA-HMO programs in the State of Wisconsin in order to disseminate material concerning this movement to interested members so that they can make individual decisions on participation; and be it further

"RESOLVED, That the Society consider development of a set of guidelines that could be used by a medical society or an individual when considering proposed third party health care programs."

15. (Brown) Cost Containment

"RESOLVED, that the State Medical Society formally endorse the concept of cost containment and adopt the 65 cost containment suggestions of the Brown County Medical Society (printed in June 1980 of *Wisconsin Medical Journal*)."

16. (Brown) Health Insurance Deductibles/Coinsurance

Because HMOs, HMPs, and various other health maintenance plans are becoming more and more prevalent within the State of Wisconsin; and such plans are greatly influencing the delivery of health care by offering virtual first dollar coverage; and we as physicians, along with consumers of health services such as union members, employers, and government, are concerned about rising costs; and over utilization increases the cost of medical services for all concerned; and the potential abuse in requesting the services of the various health care vendors under a first dollar coverage system does exist, and, in fact, such abuses are already evident; and insurance companies allege they cannot find mass market for contracts with deductibles and coinsurance in labor-management negotiations because of union demands for first dollar coverage, therefore be it

"RESOLVED, that we, the physicians of Wisconsin, urge the Wisconsin State Legislature to require some form of contribution from the ultimate consumer of medical care such as coinsurance or a deductible as a mandatory component of all health insurance policies paid by employers as a part of labor-management agreements."

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17. (Brown) Motorcycle Helmet Law

"RESOLVED, that the State Medical Society encourage the Wisconsin Legislature to reenact a mandatory helmet law."

18. (Brown) Driving While Intoxicated

"RESOLVED, that the State Medical Society of Wisconsin sponsor legislation mandating loss of freedom (suggested time incarcerated 10 days) and loss of driver's license (6 months) for those who are convicted of driving while intoxicated."

19. (Milwaukee County Delegation) Curtailment of Drug Paraphernalia Shops

Because the State Society's House of Delegates, in 1980, adopted the position which defines marijuana as a dangerous drug; and the American Medical Association, through the efforts of the Wisconsin delegation, recently adopted the same position; and the AMA report identifies model legislation prepared by the Drug Enforcement Administration which would curtail the proliferation of paraphernalia shops; therefore be it

"RESOLVED, that the State Society obtain this model legislation, make it available to component county societies, and that State Medical Society Alliance Field Consultants be requested to assist county societies in enacting appropriate ordinances at the local level."

20. (Milwaukee County Delegation) Physicians as Independent Contractors

Because the Internal Revenue Service has attempted to clarify the definition of Independent Contractors; and the 96th Congress placed an eighteen month moratorium on implementation of such definition; and Senate Bill S-8 of the 97th Congress, introduced by Senator Robert Cole on January 5, 1981, attempts "to clarify the standards for determining whether an individual is an Independent Contractor"; and many physician members of this Society consider themselves Independent Contractors even though they may be exclusively contracted to a given corporate health provider; therefore be it

"RESOLVED, that the State Medical Society of Wisconsin, through its delegation to the American Medical Association, request the appropriate American Medical Association Legislative Committee to evaluate Senate Bill S-8 and determine its impact on physician contractual relationships." ■

Proposed revision to Constitution up for action by House in March

The proposed general revision of the SMS Constitution and Bylaws, introduced in the 1980 House of Delegates and laid over in total for final action by the 1981 House of Delegates, was published in the June 1980 Blue Book issue of the *Wisconsin Medical Journal* and subsequently distributed to each component society to effect official notification. Members are urged to review this revision and submit their views to their delegates and officers. ■

Nominating Committee presents partial slate of candidates

Meeting in Madison on Sunday, September 28, the Nominating Committee chose the following slate of candidates for positions to be filled by House of Delegates elections on Saturday, March 28, 1981:

President-elect: Gerald C Kempthorne, MD, Spring Green.

Speaker of the House of Delegates: Duane W Taebel, MD, LaCrosse, to succeed himself.

Vice-speaker of the House: Chesley P Erwin, MD, Milwaukee, to succeed himself.

AMA Delegate for calendar years 1982-83: Henry F Twelmeyer, MD, Wauwatosa, to succeed himself.

AMA Delegate for calendar years 1982-83: Richard W Edwards, MD, Richland Center, to succeed Gerald J Derus, MD, Madison, who did not seek reelection.

The committee did not take final action with reference to AMA Alternate Delegates for calendar years 1982-83. The terms of John R McKenzie Jr, MD, Oshkosh, and Warren H Williamson, MD, Racine, expire at the end of 1981, both of whom indicated they did not seek reelection to those positions. (Doctor Williamson was presented to the committee as a candidate for the Delegate seat of Doctor Derus.)

Nominees appearing before the committee as candidates for AMA Alternate Delegate were Cyril M "Kim" Hetsko, MD, Madison, and Kenneth M Viste Jr, MD, Oshkosh.

It should be noted that a third AMA Alternate Delegate vacancy, for calendar year 1982, would be created by Doctor Edwards' election as Delegate.

The Nominating Committee "left open the AMA Alternate Delegate positions for further nominations and action at the annual meeting or at a special meeting."

Since the September committee meeting, the candidacy of Richard H Ulmer, MD of Marshfield, for one of the AMA Alternate Delegate positions, has been communicated to the Nominating Committee for its consideration.

Joel E Taxman, MD, Milwaukee, is chairman of the Nominating Committee, and James J Tydrich, MD, Richland Center, is secretary.

Candidates' pictures and biosketches appear elsewhere in this issue. ■

PROGRAM SCHEDULE—Annual Meeting, March 26-27-28, 1981, Milwaukee

THURSDAY, MARCH 26

AMA Delegates Open Hearing
Marc Plaza, 7:30 pm

District I Caucus
MECCA, 1:00 pm

House of Delegates First Session
MECCA, 2:00 pm (Registration, 1:00 pm)

Reference Committee Meetings
Marc Plaza, 7:30 pm

Section Delegates Caucus
Marc Plaza, 10:30 am

Wisconsin Academy of Family Physicians Breakfast and Board Meeting
Marc Plaza, 8:00 am

Women in Medicine Panel and Discussion
Marc Plaza, 7:30 pm
(Social hour, 5:30, Dinner, 6:30)

FRIDAY, MARCH 27

Cancer Pain Management Panel
MECCA, 8:00 am-11:15 am

Colorectal Carcinoma Panel
MECCA, 9:00 am-12:00 noon

District I Caucus
MECCA, 3:30 pm

Foundation for Medical Care Evaluation Panel
MECCA, 9:00 am-10:00 am

Special Reference Committee on Revision of Constitution and Bylaws
MECCA, 9:00 am

House of Delegates Second Session
MECCA, 4:00 pm (Registration, 3:30)

Medicine and Religion Breakfast
Marc Plaza, 7:15 am

Neurology Specialty Program and Luncheon
MECCA, 12:15 pm-4:30 pm

Nutrition in the Elderly Panel
MECCA, 2:00 pm-3:20 pm

Ophthalmology Specialty Program, Luncheon, and Business Meeting
MECCA, 8:00 am-5:00 pm

Ophthalmology Dinner
University Club, 6:00 pm

Physical Medicine and Rehabilitation Specialty Program and Business Meeting
MECCA, 1:30 pm-5:30 pm

Plastic Surgery Specialty Program, Luncheon, and Business Meeting
MECCA, 12:15 pm-4:30 pm

Plastic Surgery Dinner
University Club, 6:45 pm

Presidents' Reception and Dinner
Marc Plaza, 6:30 pm

Psychiatry Specialty Program
MECCA, 9:00 am-12:00 noon

Radiation Oncology Specialty Program and Luncheon
MECCA, 12:15 pm-1:30 pm

Resident Physicians Section Program
MECCA, 9:00 am-4:00 pm

Socio-economic/WISPAC Luncheon
MECCA, 12:15 pm

Urinary Incontinence Panel
MECCA, 9:00 am-10:20 am

Wisconsin Endoscopic Society Specialty Program and Business Meeting
MECCA, 2:00 pm-4:00 pm

Wisconsin Society of Radiation Oncologists Business Meeting
MECCA, 10:30 am

SATURDAY, MARCH 28

Allergy and Clinical Immunology Specialty Program
MECCA, 8:50 am-11:30 am

Computed Tomography Panel
MECCA, 10:40 am-12:00 noon

Anesthesiology Specialty Program, Luncheon, and Business Meeting
MECCA, 12:15 am-5:00 pm

Council Meeting
Marc Plaza, 10:30 am

Council and Past Presidents Luncheon
Marc Plaza, 12:00 noon

Dermatology Specialty Program and Luncheon
MECCA, 12:15 pm-4:30 pm

Diabetes Panel
MECCA, 9:00 am-10:20 am

District I Caucus
MECCA, 7:30 am

Emergency Medicine Specialty Program, Luncheon, and Business Meeting
MECCA, 12:15 pm-2:30 pm

House of Delegates Third Session
MECCA, 8:00 am (Registration, 7:30)

Internal Medicine Specialty Program and Luncheon
MECCA, 12:15 pm-4:30 pm

Neurosurgery Specialty Program and Luncheon
MECCA, 12:15 pm-2:00 pm

Orthopaedics Specialty Program, Luncheon, and Business Meeting
MECCA, 8:30 am-4:30 pm

Orthopaedics Dinner
Milwaukee Athletic Club, 6:00-10:00 pm

Otolaryngology Specialty Program, Luncheon, and Business Meeting
MECCA, 8:30 am-4:00 pm

Pathology Specialty Program, Luncheon, and Business Meeting
MECCA, 9:30 am-5:00 pm

Pituitary Disease Panel
MECCA, 9:00 am-12:00 noon

Surgery Specialty Program, Luncheon, and Business Meeting
Medical College of Wisconsin Auditorium, 8:00 am-12:00 noon; Alumni Center, 12:00 noon; MECCA, 1:30-5:00 pm

Surgical Society Dinner
University Club

Wisconsin Allergy Society Business Meeting
MECCA, 11:15 am

Wisconsin Thoracic Society Annual Meeting
MECCA, 8:00 am-12:00 noon

* * *

SCIENTIFIC PROGRAM COMMITTEE
Leonard H Wurman, MD, Wausau
Chairman
John L Raschbacher, MD, Waukesha
Co-chairman

SCIENTIFIC PROGRAM PLANNERS
Commission on Continuing Medical Education

George A Bergland, MD, Milwaukee
Chairman
Leonard H Wurman, MD, Wausau
Vice-chairman
C William Freeby, MD, Appleton
Martin Z Fruchtman, MD, Waukesha
Bradley G Garber, MD, Osseo
John T Houlihan, MD, Woodruff
James J Koch, MD, Prairie du Sac
Edwin L Overholt, MD, LaCrosse
John L Raschbacher, MD, Waukesha
Ex officio
Williard Duff, PhD (MCW)
Sigurd E Sivertson, MD (UW)
Staff
Bill Wendle, *Scientific Affairs Coordinator*
Arlene Meyer, *Administrative Assistant, Continuing Medical Education*

Here is a partial list of those candidates chosen for top State Medical Society offices by the Committee on Nominations. This is the slate on which the House of Delegates will vote at the Society's Annual Meeting March 26-28 at Milwaukee's Exposition and Convention Center and Arena (MECCA) and Marc Plaza Hotel. Be sure to let your county medical society delegate know your preferences in the next few weeks.

Incoming President
Albert J Motzel Jr, MD
Waukesha

Nominees for SMS offices; election March 28

☐ Gerald C Kempthorne, MD

President-elect of State Medical Society (1981-82)

Graduate of University of Maryland School of Medicine. Served internship at Cook County Hospital, Chicago, Ill, 1961-62. Served in the United States Navy from 1951-54. Has been in solo family practice in Spring Green since 1962. Has been a member, past president, and past secretary of medical staff of Sauk Prairie Memorial Hospital since 1962; medical director, Black Earth Manor Nursing Home in Black Earth, and presently president of River Valley School Board of Education, Spring Green. Past chairman of the Sauk County Republican Party; past president and member of Spring Green Lions Club, and member of the Chamber of Commerce in Spring Green. Served on the boards of Valley Studio (past president), Uplands Arts Council, and Spring Green Theatre Corp (past president). In 1980 became a member of board of directors of American Players Theatre, a national (Shakespeare) theatre center for the classics in Spring Green. Served on WISPAC Board of Directors, SMS Committee on Federal Legislation, SMS Mental Health Committee, and Advisory Committee on Community Program Standards for the State Department of Health and Social Services. Past president and past secretary of Sauk County Medical Society; SMS Councilor, 1979-82; chairman and member of SMS Commission on Mediation and Peer Review, and has served as chairman of the Commission's Impaired Physician Program since its inception in 1977. Serves as cochairman of the newly formed Coordinating Council for the Statewide Impaired Physician Program, established through cooperative efforts of State Medical Society of Wisconsin and Wisconsin Medical Examining Board. A member and currently chairman of Medicaid Medical Audit Committee of State Medical Society. Member of Academy of Psychosomatic Medicine, American Geriatrics Society, and fellow of the American Academy of Family Physicians. Diplomate of National Board of Medical Examiners (1962) and American Board of Family Practice (1974).

☐ Duane W Taebel, MD

Speaker of the House of Delegates (1981-83)

Graduate of University of Chicago School of Medicine, 1960. Internship at University of Chicago Hospital, 1960-61. Internal medicine residency at University of Chicago Hospital, 1961-64 and was chief resident in medicine, 1963-64. Fellow in gastroenterology, 1964-66, and was instructor, Dept of Medicine, University of Chicago Hospital. Served in US Army Hospital, Fort Devens, Mass, 1966-68. Received Wisconsin license in 1966 when joined Gundersen Clinic-LaCrosse Lutheran Hospital. Board certified in internal medicine, 1968, and recertified in 1974. Board certified in gastroenterology, 1972. Was member of American Society of Cytology and Alpha Omega Alpha Honor Medical Fraternity. Holds memberships in American Gastroenterology Association and American Society of Gastrointestinal Endoscopy. Is Fellow, American College of Physicians. Is chairman of the Department of Medicine, Gundersen Clinic, Ltd, and has served as chief-of-staff, LaCrosse Lutheran Hospital. Was president of LaCrosse County Medical Society, 1976. Has been delegate to State Medical Society since 1972 and vice-speaker of the House of Delegates in 1978. Was member of SMS ad hoc committee on redistricting. Serves on Board of Control of Wisconsin Professional Standards Review Organization (WisPRO), 1975 to present.

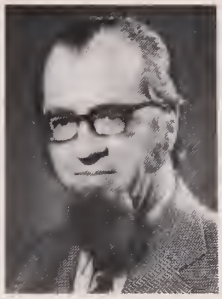
☐ Chesley P Erwin, MD

Vice-speaker of House of Delegates (1981-82)

Graduated from the School of Medicine, University of Oklahoma in 1951. Interned at Harris Hospital, Fort Worth, Tex from 1951-52 and residency in pathology at Milwaukee County General Hospital, 1952-55 and Lutheran Hospital, Milwaukee, 1955-56. Served in the United States Armed Forces, 1942-46. Board certified in Anatomic and Clinical Pathology in 1956; certified in sub-

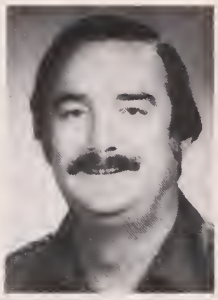
Doctor Kempthorne

Doctor Taebel



Doctor Erwin

Doctor Twelmeyer



Doctor Edwards

specialty in Forensic Pathology in 1976. Is professor of pathology at the Medical College of Wisconsin, and also is medical examiner of Milwaukee County serving from 1972 to the present. Is fellow of College of American Pathologists, American Society of Clinical Pathologists, and the American Academy of Forensic Sciences. Is member of the International Academy of Pathology, International Association of Coroners and Medical Examiners, New York Academy of Sciences, Milwaukee Academy of Medicine, American Association for the Advancement of Sciences, Wisconsin Coroners Association, Wisconsin Society of Pathologists, and National Association of Medical Examiners. Served as president of the Medical Society of Milwaukee County, 1976; president of the Wisconsin Society of Pathologists, 1971-73; and president, Faculty Assembly, Medical College of Wisconsin from Nov 1970 (inception) until July 1971. Is member of Council and past president of Milwaukee Academy of Medicine; member, Board of Directors, Foundation for Medical Care Evaluation of Southeastern Wisconsin, Inc; delegate from Milwaukee county to State Medical Society of Wisconsin; member, Health Plan Committee, Health Systems Agency of Southeastern Wisconsin; member, operating Committee, Milwaukee Health Protection Plan; member, University of Wisconsin System Medical Technology Advisory Committee; and vice-chairman of WISPAC, 1979-1981. Served on the medical staff of Family Hospital, Milwaukee, from 1956-66 and presently is on the staff of Milwaukee County General Hospital, since 1966.

☐ Henry F Twelmeyer, MD

Delegate to American Medical Association (1982 & 1983)

Graduate of Marquette University School of Medicine, Milwaukee. Received internship at Milwaukee County General Hospital, 1942 to 1943. Served residency at Milwaukee County General Hospital, 1946-1949. Received license to practice medicine in 1943 and began practice of general and vascular surgery in Milwaukee in 1950. Has been SMS alternate delegate to American Medical Association since 1971 and delegate since 1976. Was president of The Medical Society of Milwaukee County in 1971, served as member of that county's board of directors through 1974, and is currently its delegate to State Medical Society. Is a member and past president of Milwaukee Academy of Surgery and past member of Council of Wisconsin Surgical Society. Currently is president-elect of Wisconsin Surgical Society. Is fellow of American College of Surgeons, diplomate of American Board of Surgery, and member of Milwaukee Academy of Medicine. Is past chief-of-staff at West Allis Memorial Hospital and has been chief of surgery at both West Allis Memorial and Elmbrook Memorial hospitals. Is associate clinical professor of surgery at Medical College of Wisconsin. Is past member of Board of Directors of Surgical Care-Blue Shield and past chairman of its Operating Committee. Is also member of Wisconsin Heart Association.

☐ Richard W Edwards, MD

Delegate to American Medical Association (1982 & 1983)

Graduated from the University of Wisconsin Medical School, Madison, in 1960, and served a rotating internship at Saint Vincent's Hospital, Toledo, Ohio from 1960-61. Served in the United States Navy from 1950-54 and has been in Family Practice in Richland Center from 1961 to present. Served as president of Richland County Medical Society in 1963 and 1980 and also as delegate to the State Medical Society of Wisconsin from 1966-69. Is certified by American Board of Family Practice and also a member of the American Academy of Family Physicians. Served as chief-of-staff, Richland Hospital, Richland Center, Wisconsin in 1963 and 1980, and also was Richland County Coroner from 1966-1978. Served as Councilor of State Medical Society of Wisconsin from 1969-1978 from District II and also was vice-chairman of the SMS Council from 1976-78. He presently is serving as treasurer of SMS (1980-81). He served as chairman of the Finance Committee of SMS Council from 1972-78. From 1969-71, he was a member of the Governor's Special Task Force for Health Manpower for the State of Wisconsin and from 1976-77, he was a member of the Governor's Committee to survey health facilities in the Wisconsin State Prison System. He has been a member of the State Medical Society's Commission on Peer Review since 1969. He served as an instructor at the University of Wisconsin School of Nursing Post Graduate Program for Nurse Practitioners in 1977-80, and has been a participant in the Summer Externship Program for Freshmen Medical Students, sponsored by Wisconsin Academy of Family Physicians since 1970 and a tutor for third-year clerkship in Family Practice, University of Wisconsin Medical School, 1980. He presently is an alternate delegate to AMA from Wisconsin, serving since 1979. Treasurer of SMS Services, Inc, 1979 to present. Serves as vice-chairman of the Medicaid Medical Audit Committee of the State Medical Society. ■

Membership Directory UPDATE

Prepared from the January 22, 1981 Membership Report for updating the 1980-81 Membership Directory

BARRON-WASHBURN-BURNETT

Address changes

New	*Old*
FP **Goetsch, Frederick H** 707 Ash St Spooner WI 54801 (715) 635-2151	418 Oak St

BROWN

Address changes

New	*Old*
P **O'Neill, Michael J** 3239 Delahaut St Green Bay WI 54301	1320 Mahon Ave

CHIPPEWA

Address changes

New	*Old*
GP **Hendrickson, Robert L** 112 Third St Cornell WI 54732 (715) 239-6344	12 Third St
GP GS **Sazama, Frank B** 928 First Ave, #1 Chippewa Falls WI 54729	Hotel Northern

COLUMBIA-MARQUETTE-ADAMS

New members

FP
Gregory, David D
916 Silver Lake Dr
Portage WI 53901
(608) 742-7171

ORS
Taylor Jr, Stewart F
1015 W Pleasant St
Portage WI 53901
(608) 742-8389

DANE

New members

PTH
Shih, Samuel C
36 South Brooks St
Madison WI 53715
(608) 267-6268

AN
Springman, Scott R
Dept Anesthes, CSC
600 Highland Ave
Madison WI 53792

Address changes

New	*Old*
OBG **Crumpacker, Margaret** 2065 Half Day Rd, #D410 Deerfield IL 60015	2203 Linden Dr Valparaiso IN 46383
GP **Olson, Warren A** 600 Highland Ave Madison WI 53792	427 Lorch St Madison WI 53706
P **Thorner, Brooke J** 2639 Mason St Madison WI 53705	2533 Kendall Ave
GS **Zonnebelt, Steven M** Dept Gen Surg, CSC 600 Highland Ave Madison WI 53792	5118 Sherwood Rd Madison WI 53711

County society transfers

Kurtz, Jeffrey A — to: Marathon

EAU CLAIRE-DUNN-PEPIN

New members

FP
Smith, Douglas L
2618 Beverly Hills Dr
Eau Claire WI 54701
(715) 839-8538

Address changes

New	*Old*
IM **Frase, Louis H** 733 W Clairemont Ave Eau Claire WI 54701	Rt 7
IM NEP **Macken, Patrick D** 733 W Clairemont Ave Eau Claire WI 54701	Rt 3 Elderberry Rd
PUD IM **Resar, Roger K** 733 W Clairemont Ave Eau Claire WI 54701	704 Pamona Dr Altoona WI 54720
OBG **Stenzel, Steven D** 733 W Clairemont Ave Eau Claire WI 54701	2812 Marilyn Dr

FOND DU LAC

New members

DR
Antlfinger, Thomas J
481 E Division St
Fond du Lac WI 54935
(414) 921-2300

FP
Pennings, Alfred G
481 E Division St
Fond du Lac WI 54935

GS
Freeman, Thomas E
80 Sheboygan St
Fond du Lac WI 54935

GREEN

Address changes

New	*Old*
N **Salanova, Vicenta** Dept of Neurology Fitzsimons Army Hosp Aurora CO 80045	Army Medical Center 12101 Colfax Ave E Denver CO 80240

Removed from membership

Salanova, Vicenta

GREEN LAKE-WAUSHARA

Address changes

New	*Old*
GS **Luy, Enrique W** PO Box 141 Wild Rose WI 54984 (414) 622-3254	(addition)
GP **Wichmann, Rodney D** PO Box 128 Wild Rose WI 54984 (414) 622-3329	(addition)

IOWA

Address changes

New	*Old*
GP **Breier, Harald P L** PO Box 185 Montfort WI 53569 (608) 943-6161	207 Main St

LA CROSSE

New members

D **Baumgaertner, Carl J** 1836 South Ave La Crosse WI 54601 (608) 782-7300	DR **Kim, Yung So** 1836 South Ave La Crosse WI 54601 (608) 782-7300

Deceased members

Norris, Thomas C—Jan 8, 1981

MARATHON

County society transfers

PS **Kurtz, Jeffrey A** 1010 Bird St Wausau WI 54401	from: Dane

MILWAUKEE

Address changes

New	*Old*
R **Abrams, Julian E** PO Box 1644 Milwaukee WI 53201	3940 N 58th St Milwaukee WI 53216
U RET **Calvy, Donald W** 950 N 75th St Wauwatosa WI 53213	750 N 75th St
GP **Gabby Jr, Samuel L** 821 E Buttles Rd Milwaukee WI 53217	720 E Wisconsin Ave Milwaukee WI 53202
D OS **Kersting, David W** PO Box 11-0 Milwaukee WI 53201	PO Box 26509 Milwaukee WI 53226
PUD **Levy, Stuart A** 9509 N Wakefield Ct Milwaukee WI 53217	3249 S 18th St PO Box 15395 Milwaukee WI 53215
IM CD **Lipoff, Jay I** 4100 W Cherrywood La Brown Deer WI 53209	2040 W Wisconsin Ave Milwaukee WI 53233
IM **Margolis, Irwin** 11437 N Oriole Lane Mequon WI 53092	PO Box 15395 Milwaukee WI 53215
IM **Mathai, George** 13450 Dunwoody Dr Elm Grove WI 53122	PO Box 11-0 Milwaukee WI 53201
FP **Moede, James G** PO Box 41 King WI 54946 (715) 258-5586	Wisconsin Veterans Home
DR GP **Panish, Richard M** PO Box 1644 Milwaukee WI 53201	Drawer 11-0
D **Schulz, Caryn I** 733 W Clairemont Ave Eau Claire WI 54701	1759 Drummond St
R **Stockland, Leo** PO Box 1644 Milwaukee WI 53201	Drawer 11-0
PTH **Storey, James D** 5515 S Bonnie Lane Hales Corners WI 53130	2900 W Oklahoma Ave Milwaukee WI 53215

Deceased members

Goodman, Paul P—Jan 12, 1981
Wilkinson, Edward D—Jan 6, 1981
Thatcher, Donald S—Oct 27, 1979

FEATURED SPEAKERS—Annual Meeting Scientific Program, March 27-28, 1981

Medicine and Religion Breakfast
Fri, Mar 27, 7:15 am, Marc Plaza
The Most Reverend Richard J Skiba
Auxiliary Bishop of Milwaukee
Archdiocese of Milwaukee
Ministry of Healing—Signs of the Kingdom

Panel on Colorectal Carcinoma
Fri, Mar 27, 9-12 noon, MECCA
R W Beart Jr, MD, Rochester, Minn
Department of Surgery, Mayo Clinic
Surgical Management
D E Dosoretz, MD, Boston, Mass
Department of Radiation Medicine, Massachusetts General Hospital
Adjunctive Therapeutic Radiology

Neurology Specialty Program
Fri, Mar 27, 12:15-4:30 pm, MECCA
J Kiffin Penry, MD, Winston-Salem, NC
Professor of Neurology and Associate Dean for Neurosciences Development, Bowman Gray School of Medicine
Treatment of Seizures

Ophthalmology Specialty Program
Fri, Mar 27, 1:15 pm, MECCA
Lorenz E Zimmerman, MD, Washington, DC
Chairman, Department of Ophthalmic Pathology, Armed Forces Institute of Pathology
Trilateral Retinoblastoma and New Tumors in Survivors

Physical Medicine and Rehabilitation Specialty Program
Fri, Mar 27, 1:30 pm, MECCA
Ernest W Johnson, MD, Columbus, Ohio
Professor and Chairman, Department of Physical Medicine, Ohio State University
Role Models for Rehabilitation in Hospitals Serving Communities Under 50,000 People

Plastic Surgery Specialty Program
Fri, Mar 27, 12:15 pm, MECCA
Thomas M Biggs, MD, Houston, Texas
Cronin-Brauer-Biggs Clinic Association
Recent Advances in Plastic Surgery

Radiation Oncology Specialty Program
Fri, Mar 27, 12:15 pm, MECCA
D E Dosoretz, MD, Boston, Mass
Department of Radiation Medicine, Massachusetts General Hospital
Update on Intra-operative Radiation Therapy—Recent Massachusetts General Hospital Experience

Panel on Pituitary Disease: Diagnosis and Treatment
Sat, Mar 28, 11:00 am, MECCA
George T Tindall, MD, Atlanta, Ga
Professor and Chairman, Division of Neurological Surgery, Emory University
Surgical Treatment of Pituitary Lesions

Allergy and Clinical Immunology Specialty Program
Sat, Mar 28, 8:50 am, MECCA
Gary W Hunninghake, MD, Bethesda, Md
Senior Investigator, National Institutes of Health
Inflammatory and Immune Mechanisms in Idiopathic Pulmonary Fibrosis

Dermatology Specialty Program
Sat, Mar 28, 1:00 & 2:05 pm, MECCA
James E Rasmussen, MD, Ann Arbor, Mich
Associate Professor of Dermatology University of Michigan Hospital
What's New in Pediatric Dermatology

Emergency Medicine Specialty Program
Sat, Mar 28, 1:00 pm, MECCA
James Nieman, MD, Los Angeles, Calif
Department of Emergency Medicine UCLA Medicenter
Advances in Cardiac Resuscitation

Neurosurgery Specialty Program
Sat, Mar 28, 1:00 pm, MECCA
George T Tindall, MD, Atlanta, Ga
Professor and Chairman, Division of Neurological Surgery
Neurosurgical Case Presentations

Internal Medicine Specialty Program
Sat, Mar 28, 2:10 pm, MECCA
Frederick J Service, MD, Rochester, Minn
Department of Medicine, Section of Endocrinology, Mayo Clinic, Mayo Clinic Graduate School of Medicine
Insulin and Variations in Its Delivery to the Patient

Sat, Mar 28, 3:00 pm, MECCA
David Sutherland, MD, Rochester, Minn
Department of Surgery, University of Minnesota
Islet Cell Transplantation for Diabetes
(Elvehjem Memorial Lecture)

Orthopaedics Specialty Program
Sat, Mar 28, 10:30 & 1:30 pm, MECCA
Charles O Townley, MD, Port Huron, Mich
The theory of the mechanics of joint design and practical applications of the theory will be discussed

Otolaryngology Specialty Program
Sat, Mar 28, 11:00 am & 2:00 pm, MECCA
William Panje, MD, Iowa City, Iowa
Associate Professor of Otolaryngology
Myocutaneous Flaps in Head and Neck Reconstruction
Prosthetic Vocal Rehabilitation of the Laryngectomized Patient

Pathology Specialty Program
Sat, Mar 28, 10:00 am, MECCA
Hun Kim, MD, Irvine, Calif
Associate Professor, City of Hope Medical Center, Department of Pathology, University of California-Irvine
Current Status of Large Cell Lymphomas
Seminar: Hematopoetic and Lymphoreticular Disorders (Moderator)

Surgery Specialty Program
Sat, Mar 28, mid-afternoon, MECCA
Ward O Griffen, MD, Lexington, Ky
Professor and Chairman, Department of Surgery, Albert B Chandler Medical Center, University of Kentucky
Gastric Secretion—From William Beaumont to the Present (Gastric Pouches I Have Known)
(William Beaumont Memorial Lecture)

* * *

Complete program mailed to members in mid-February

ONEIDA-VILAS

Deceased members

Wright, Marvin—Dec 27, 1980

OUTAGAMIE

Address changes

New	*Old*
PTH **Cordero, Armenio C** 1506 S Oneida St Appleton WI 54911	Rt 3, Rip Van Winkle La
R **Hausserman, Sue A** 411 Lincoln Ave Neenah WI 54956	308 E 14th St Kaukauna WI 54130

RICHLAND

New members

FP **Bard, Neil N** 1313 W Seminary St Richland Center WI 53581 (608) 647-6161	FP **Jordan, John C** 1313 W Seminary St Richland WI 53581 (608) 647-6161

SAUK

Address changes

New	*Old*
GP OBG **Rouse, John J** Rt 1, Box 380B Reedsburg WI 53959 (608) 524-3486	PO Box 348

SHAWANO

Deceased members

Grover Jr, William W—Jan 10, 1981

WALWORTH

Address changes

New	*Old*
FP **Rogers, Richard J** PO Box 547 Elkhorn WI 53121 (414) 723-3100	100 S Washington St

WAUKESHA

New members

IM ID **Dailey, Michael P** W180 N7950 Town Hall Menomonee Falls WI 53051	P **Patel, Malti M** 250 W Broadway Waukesha WI 53186

WOOD

Address changes

New	*Old*
IM GE **Manier, James W** 807 W 5th St Marshfield WI 54449	Rt 4 Sugarbush Lane ■

Medical Assistants

FEBRUARY 1981

cma

PROFESSIONAL DEVELOPMENT AND ADVANCEMENT SEMINAR

Holiday Inn, Green Bay Saturday, March 7, 1981

The American Association of Medical Assistants, Inc., Wisconsin Society, sponsored a Professional Development and Advancement Seminar in Green Bay on November 8, 1980.

The program consisted of: Emergency First Aid presented by Nancy Schlapman, RN; Public Relations, Every Member's Responsibility by Barbara B Schumann, CMA-A; and Hospital Emergency Room Procedures and Philosophy by William E Hein, MD.

There were 100 participants registered and 50% of these applied for Continuing Education Units.

The American Association of Medical Assistants, Inc, Wisconsin Society will sponsor another Professional Development and Advancement Seminar at the Holiday Inn, Green Bay, on Saturday, March 7, 1981.

Topics will include: A three-hour program on Basic Disaster by James Joyce, Wisconsin Division of Health, EMS Systems Development Section, Madison; A two-hour program on Athletic Injuries by Rolf Lulloff, MD, Orthopedic Surgeon from Green Bay; and Randy Griswald, RTR, Amercian Association of Medical Assistants, Inc, Wisconsin Society, and Director of Radiologic Technology at Bellin Hospital, Green Bay, will give a one-hour presentation on Radiation Exposure.

Continuing Education Units will again be available.

For further information on the March Seminar, please contact Karen DeBruin, CMA, Education Chairman, 1319 Sunset Lane, Menasha, WI 54952.

Sandra Doyle, CMA-C
Public Relations Chairman
AAMAI-Wisconsin Society
929 Grove Ave, Apt 2
Wisconsin Rapids, WI 54494
(715) 423-3500 ■

Obituaries

✓County, State, and AMA members

CORRECTION!

In the membership report of Dec 15, 1980, published in the January 1981 issue of the *WMJ*, it was erroneously reported that John D Charles, MD, Milwaukee County, was deceased. Doctor Charles is alive; it was his wife who had died. The Membership Department and the *WMJ* regret this error . . . our apologies to Doctor Charles for any confusion or embarassment this may have caused him.

A R Bellerue, MD, Marina Del Ray, Calif, died Aug 17, 1980 in Marina Del Ray, Calif. Doctor Bellerue had practiced medicine in the Iola area from 1919-1931 and started the Iola Hospital in 1920. He also practiced medicine in Waupaca and Lake Geneva, Wisconsin and in Michigan and California for 50 years. Surviving are his widow and three children.

✓**Robert E Flynn, MD,** 98, LaCrosse, died Oct 29, 1980 in LaCrosse. Born Feb 1, 1882 in Caledonia, Minn, Doctor Flynn graduated from Rush Medical College, Chicago, Ill, in 1910 and served his internship at St Francis Hospital, LaCrosse. Doctor Flynn practiced in LaCrosse until his retirement in 1966. He had served on the Medical Examining Board for the State of Wisconsin for many years and also served as secretary for 16 years. He was a former chief-of-staff of St Francis Hospital and had served as president of the LaCrosse County Medical Society. In 1961 he was named to the "Fifty Year Club" of the State Medical Society and in 1970 he was awarded a gold pin by the Rush Medical College commemorating 60 years of medical practice. Surviving are his widow, Marie; six sons, Dr Robert A, Scottsdale, Ariz; Dr Thomas E, Sterling, Ill; Dr George E, Milwaukee; John E and Donald E, both of LaCrosse; and Professor Patrick J, Bowie, Md; and one daughter, Mrs Joseph (Mary) McCarthy of Caldedonia, Minn.

✓**Milton Finn, MD,** 66, Superior, died Oct 30, 1980 in St Louis Park, Minn. Born Nov 22, 1913 in New York, Doctor Finn graduated from the University of Wisconsin Medical School, Madison, in 1938. His internship was served at the Touro Infirmary in New Orleans, La. Doctor Finn had practiced medicine in Superior since 1940, retiring in 1978. He was the founder of the Superior Clinic. Doctor Finn had served on the SMS Commission on Medical Care Plans from 1949-1977 and on the WPS board of directors from 1977 until his death. He also had served as president and secretary of the Douglas County Medical Society and as chief-of-staff of St Mary's Hospital in Superior. Surviving are his widow, Mollie; a daughter, Mrs Michael (Natalie) Birnbaum, St Louis Park, Minn; two sons, Mark, New Hope, Minn, and Dr Sidney Finn of Des Moines, Ia, and four grandchildren.

✓**Michael E Korns, MD,** 47, Elm Grove, died Nov 19, 1980 in Milwaukee. Born Feb 4, 1933 in Iowa City, Iowa, Doctor Korns graduated from the University of Iowa Medical School in 1959 and served his internship at the United States Naval Hospital, Bethesda, Md. His residency was taken at the University of Iowa. A professor of pathology at the Medical College of Wisconsin, Milwaukee, Doctor Korns also was vice chairman of Pathology and assistant director of Laboratories at the Milwaukee County Medical Complex. Surviving are his widow, Shirley; three daughters, Patricia, Ann, and Rebekah; and a son, Peter.

Harold Barrick Miner, MD, 81, Milwaukee, died Nov 28, 1980 in Milwaukee. Born Dec 15, 1898 in Humberstone, Ontario, Canada, Doctor Miner graduated from the University of Toronto Medical School in 1923. His internship was taken at St Michael Hospital, Toronto, Canada, and Columbia Hospital in Milwaukee. A pediatrician, Doctor Miner had served the Milwaukee area for 57 years. Surviving is a son, John, of Boston, Mass.

Arthur K Peterson, MD, 73, Delavan, died Dec 4, 1980 in Delavan. Born May 3, 1907 in Chicago, Ill, Doctor Peterson graduated from the University of Illinois Medical School in 1936. He served in the United States Army from 1942-1945 and from 1947-1966, he was corporate medical director of the R R Donnelley & Son publishing house in Chicago, Ill. Surviving are his widow; a son, Arthur K Jr of Washington, DC, and a daughter, Mrs Mary Susan Marnul of South Holland, Ill.

✓**Ralph T Anderson, MD,** 70, Superior, died Dec 11, 1980 in Duluth, Minn. Born Jan 23, 1910 in Superior, Doctor Anderson graduated from Temple University School of Medicine, Philadelphia, Pa, in 1940, and served his internship and residency at Ancker Hospital in St Paul, Minn. After serving as Flight Surgeon with the 8th Army Air Corps in the ETO during World War II, he served another residency at the University of Minneapolis. Doctor Anderson was a life member of the medical staff of Superior Memorial Hospital and also was a founder of the Superior Clinic. Surviving are his widow, Berniece; two sons, Keith, Minneapolis, and Roger, Wiesbaden, Germany, and one daughter, Mrs Rodney C (Joyce) Munson of Eau Claire.

Herbert A Raube, MD, 82, Beloit physician for 48 years, died Dec 12, 1980 in San Rafael, Calif. Born Jan 17, 1898 in Waupun, Doctor Raube graduated from the University of Chicago Medical School in 1924 and served his internship at Wisconsin General Hospital, Madison. He was a past president of Beloit Memorial Hospital and was a member of the American College of Surgeons. Surviving are two sons, Jerome H, San Rafael, Calif, and Peter Lee of Denver, Colo.

✓**Henry I Okagaki, MD,** 67, Madison, died Dec 17, 1980 in Madison. Born Dec 11, 1913 in San Jose, Calif, Doctor Okagaki graduated from Stanford University School of Medicine in 1943 and served his internship and residency at University Hospitals in Madison. He

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served in the United States Army Medical Corps from 1943-1946. In 1949 he joined the University of Wisconsin's Medical School faculty. Widely known for his work in children's orthopedics, Doctor Okagaki was one of the first doctors in Wisconsin to practice children's orthopedics. He also was widely recognized for his expertise with amputees. Doctor Okagaki developed University Hospital's Amputee Clinic, and he directed the Cerebral Palsy Clinic. Surviving is his widow.

Harold F Borenz, MD, 61, Madison, died Dec 23, 1980 in Madison. Born Aug 26, 1919 in Neenah, he graduated from the University of Michigan in 1945. His internship was taken at Jersey City Medical Center and his residency was served at the University of Wisconsin in Madison. Surviving is his widow, Mary of Madison.

Donald J Welter, MD, 60, chairman of the Department of Family Practice of the Medical College of Wisconsin, Milwaukee, died Dec 23, 1980 in Elm Grove. Born Mar 9, 1920 in Superior, Doctor Welter graduated from Marquette University School of Medicine in 1952. He served his internship at Misericordia Hospital in Milwaukee. Doctor Welter practiced medicine in Shell Lake where he was chief-of-staff at Indianhead Memorial Hospital and also served as president of the Barron-Washburn-Sawyer-Burnett County Medical Society. He joined the medical faculty of the Medical College of Georgia in Augusta in 1971 and also was medical director of the Georgia War Veterans Nursing Home. He returned to Wisconsin in 1976 to become professor and chairman of the Department of Family Practice at the Medical College of Wisconsin. Surviving are his widow, Kathryn; three daughters, Mrs John (Nancy) Peter, Spooner; Mrs John (Mary) Rogers, Raleigh, NC; and Elizabeth, Madison; three sons, John, Madison; Joseph, Milwaukee; and Frederick of Elm Grove.

Terryl B Montgomery, MD, 49, New York, died Jan 14, 1981 in New York. Born May 13, 1931 in Milwaukee, Doctor Montgomery graduated from the University of Wisconsin Medical School, Madison, and served his internship at Mary Fletcher Hospital in Burlington, Vermont. Surviving are five children. ■

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SERVING SOUTHERN-CENTRAL WISCONSIN

News Highlights

*Physician members of State Medical Society of Wisconsin

Memorial Hospital medical staff, Manitowoc, recently elected Thomas L Finnegan, MD,* to a two-year term as president of its staff. Doctor Finnegan, an orthopedic surgeon, has been on the medical staff of Memorial Hospital since 1977. Other MDs elected to office are Edward J Barylak,* vice-president; and Gary Schmidt,* secretary-treasurer.

St Nicholas Hospital medical staff, Sheboygan, has reelected Burnell F Eckardt, MD,* to a second term as president of its staff. Doctor Eckardt has been in private medical practice in Sheboygan since 1946. Also elected as officers of the staff are MDs Otto K Stewart,* vice-president, and Paul M Fleming,* secretary-treasurer.

Milwaukee Psychiatric Hospital recently appointed Clifford Simske, MD,* Wauwatosa, its medical director. Doctor Simske graduated from Marquette University School of Medicine and completed his residency at Cherokee Mental Health Institute, Cherokee, Iowa. He served for one year as unit chief of the Veterans Administration Hospital, Sheridan, Wyoming and has been in private practice in Idaho and Kentucky. He has been on the medical staff of the Hospital since 1978.

Foundation for Medical Care Evaluation of Southeastern Wisconsin, Inc has elected Thomas G Dehn, MD* as its president, succeeding Kenneth O Johnson, MD, Milwaukee. Doctor Dehn is a member of the medical staff of Good Samaritan Medical Center, Milwaukee; a commissioner of the State Medical Society's Physicians Alliance Commission; and a member of the board of the American Association of Professional Standards Review Organizations.

Randle Pollard, MD,* Milwaukee, was elected vice president, succeeding Philip J Taugher, MD,* West Allis. Lee W Baker, president of Lee Baker & Associates, Inc, Milwaukee, was elected secretary, succeeding David N Goldstein, MD,* Kenosha. Mark C Kiselow, MD, Milwaukee, was reelected treasurer.

Jerome Coquillard, executive director of FMCESWI, also announced the election of four new members to the board of directors: Irwin J Bruhn, MD,* Walworth; Gerald J Dorff, MD, Wauwatosa; Robert L McGlynn, administrator, Elmbrook Memorial Hospital, Brookfield; and Richard Stone, MD,* Whitefish Bay.

The Foundation is a professional standards review organization (PSRO) that serves the seven counties of southeastern Wisconsin. Formed in 1973, the Foundation monitors the quality and cost of hospital care reimbursed under Medicaid and Medicare programs as well as under participating private hospitalization insurance plans.

Holy Family Hospital medical staff, Manitowoc, recently elected Robert D Bush, MD* as its president. Doctor Bush, a pediatrician at the Manitowoc Clinic, has practiced medicine at Holy Family Hospital for the past 21 years. During that time he has served on a number of committees, as well as the executive committee, and also as the president of the Manitowoc County Medical Society. ■

County Societies

*Physician members of State Medical Society of Wisconsin

MILWAUKEE: The Medical Society of Milwaukee County recently honored the accomplishments of its members at the Society's 134th annual membership meeting. Distinguished Service Awards were presented to eight physicians for their contributions to the medical profession and the Milwaukee community. MDs who received the awards were Walter P Blount* and Albert C Schmidt* for their co-development of the Milwaukee Brace; Mortimer M Bortin* for his research achievements with bone marrow transplants; H Myron Kauffman* for his pioneer efforts with kidney transplants; George H Lane* for his efforts in reducing the incidence of sickle cell disease; Harold D Itskovitz* and Constantine Panagis* for their co-development of the community wide hypertension screening concept; and Joseph C Darin* for developing "the finest paramedic program in the nation."

SHEBOYGAN: Sheboygan County Medical Society officers for the year 1981 are MDs James B Kuplic,* Sheboygan Falls, president; Christopher Graf,* Sheboygan, vice-president and president-elect; James Weygandt,* Sheboygan Falls, secretary-treasurer; Stephen Westcott* and Robert Keller,* Sheboygan, delegates to the State Medical Society; and Patrick Marsho,* Sheboygan, as an alternate delegate.

MILWAUKEE: The Medical Society of Milwaukee County has announced its officers for 1981: President—Charles Landis, MD;* President-elect—Glenn H Franke, MD;* Secretary-Treasurer—Marvin Glicklich, MD.* Newly elected board members include Doctors Andrew Boyd,* Jerome W Fons,* Lucille B Glicklich,* Dean D Miller,* Richard H Strassburger,* Joseph L Teresi,* and HM Waldren.* Retiring Society President, Walter J Woloschek, MD,* was elected as Director of the Board. Elected as Delegates to the State Medical Society of Wisconsin were Doctors Paul A Dudenhoefer,* William E Finlayson,* George F Flynn,* Harry R Foerster,* Marvin Glicklich,* Michael T Jaekels,* Stanley A Korducki,* Roger E Laubenheimer,* James A Means,* Dean D Miller,* Shimpei Sakaguchi,* Kendall E Sauter,* Kenneth M Smigielski,* Walter J Woloschek* and Raymond C Zastrow.* ■

Physician Briefs

*Physician members of State Medical Society of Wisconsin

Stephen L Weld, MD,* Two Rivers physician for 37 years, was honored in December for his service to the community. Doctor Weld, who has practiced medicine for 40 years, is retiring from his medical practice. He graduated from Temple University Medical School in 1940 and served his internship at St Joseph Hospital in Milwaukee. His residency was taken at St Mary's Hospital, Racine, and his general surgery residency was at Henry Ford Hospital in Detroit. He moved to Two Rivers in 1943.

Y Gregory Lin, MD, Marshfield, has joined the Department of Medical Oncology at the Marshfield Clinic. Doctor Lin completed his medical training at Taipei Medical College, Taiwan, and served his internship and residency in internal medicine at Illinois Masonic Medical Center in Chicago. Doctor Lin had a fellowship in oncology and hematology at Stanford University Medical Center, Palo Alto, Calif, and for the past five years has been in private practice in Beverly Hills, Calif.

Juanilito N Seldera, MD recently became associated with the Walworth Medical Group. He graduated from the University of the East, College of Medicine, Quezon City, The Philippines. He completed his internship at St Peter's Hospital, Albany, NY, and his residency training in surgery at Maimonides Medical Center, St John's Episcopal Hospital, and Downstate Medical Center of New York. His wife, Doctor Joy Seldera, is a specialist in obstetrics and gynecology.

Joseph Bachir, MD, Ladysmith, recently began his medical practice at the Ladysmith Medical Center. His medical education was received at the University of Moscow and his postgraduate work was taken in England and Scotland. In 1980 he was named research fellow for the World Life Research Institute in Colten, Calif, and recently was a cardiothoracic fellow at Sinai Hospital in Detroit.

Leonard R Worden, MD, Marinette, recently joined the staff of the Boren Clinic in the Department of Family Practice. Doctor Worden graduated from the University of Michigan Medical School and served his residency in family practice at the University of North Dakota in Bismarck. Prior to joining the Clinic, Doctor Worden had worked as an emergency medical physician in North Dakota.

Daniel J McCarty, MD,* Hartland, recently was appointed to the editorial board of the *American Journal of Medicine.* Doctor McCarty is professor and chairman of the Department of Medicine at the Medical College of Wisconsin, Milwaukee, and director of the Department of Medicine at Milwaukee County Medical Complex. He is past president of the American Rheumatism Association, Section of the Arthritis Foundation. He is editor-in-chief of the 9th edition of *Arthritis and Allied Conditions,* long regarded as the definitive reference textbook of rheumatology. Doctor McCarty joined the Medical College of Wisconsin in 1974.

William E Braun, MD,* Merrill, recently retired from his medical practice. An orthopedic surgeon, Doctor Braun had practiced in the Merrill area for over 26 years. He graduated from Marquette University School of Medicine and served his internship while in the United States Navy. His residency in orthopedics was completed at the Veterans Administration Hospital and the Milwaukee Children's Hospital. He practiced in Kenosha before returning to his home town in 1954.

Jacob George, MD, New Berlin, recently was appointed assistant professor of psychiatry and mental health sciences at the Medical College of Wisconsin, Milwaukee. Doctor George graduated from the University of Kerala, India, and served his internship at the Medical College Hospital in Trivandrum, India. He completed his residency training in psychiatry at the College of Medicine and Dentistry of New Jersey and New Jersey Medical School Affiliated Hospitals.

Robert Montgomery, MD, Mequon, recently was appointed assistant professor of pediatrics at The Medical College of Wisconsin. Currently he is medical director of the Great Lakes Hemophilia Foundation and is at Milwaukee Children's Hospital and the Blood Center of Southeastern Wisconsin. Doctor Montgomery previously taught at the University of Colorado Health Sciences Center, Denver, and also was the assistant director of the Mountain States Regional Hemophilia Center in Denver.

Homer Carter, MD, (above) Madison physician for 50 years, recently was named the "Honorary Citizen of the Month" by the First Wisconsin National Bank of Madison. Doctor Carter, who retired from medical practice in 1965, graduated from Rush Medical College in 1915 and began his professional career in Madison in 1917. He delivered between 8,000 and 9,000 babies including two sets of triplets. At the presentation ceremony, comments were made by Earl Thayer, secretary and general manager of the State Medical Society of Wisconsin; Gordon Johnsen, president of Madison General Hospital; and former nurses, friends and relatives. (Photo by Reierson Studio)

Wisconsin Society of Anesthesiologists recently named John J Vondrell, MD,* Brookfield, as president. Doctor Vondrell, past chief of anesthesiology at Elmbrook Memorial Hospital, is a graduate of Marquette University School of Medicine. He has been a member of the Elmbrook medical staff since 1971. He is a diplomate of the American Board of Anesthesiology as well as a fellow of the American College of Anesthesiology.

American Association for Hand Surgery has elected George L Lucas, MD,* Madison, as president-elect for 1981. He became a member of the Association in 1971. He graduated from George Washington University Medical School, Washington, DC, and served his internship and residency at the University of Wisconsin Medical School in Madison.

The North Central Section of the American Urological Association recently elected John D Silbar, MD,* Milwaukee, as its secretary. Doctor Silbar is chief-of-staff at Mt Sinai Medical Center, an affiliated hospital with the University of Wisconsin Medical School, Madison, and the Medical College of Wisconsin in Milwaukee.

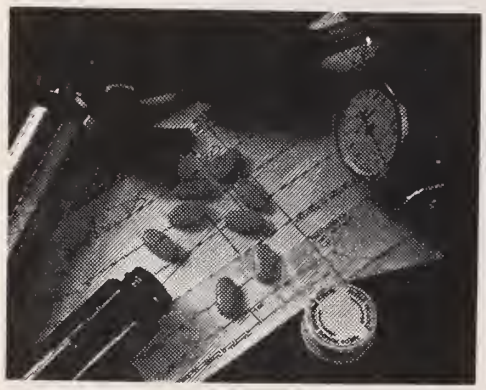
The American Academy of Pediatrics has named Stephen C Copps, MD,* LaCrosse pediatrician, to its editorial board which is writing a manual on developmental disabilities. The manual is designed to help doctors with the care of children having a variety of disabilities. Doctor Copps is director of the Gundersen Clinic's Comprehensive Child Care Center which provides a team approach to care of children with cerebral palsy and related conditions. He also is vice-chairman of the American Academy of Pediatrics Committee on Care of Children with Handicaps.

American Academy of Dermatology has named Stephen B Webster, MD,* LaCrosse, to its board of directors. Doctor Webster also is associate clinical professor of dermatology at the University of Minnesota Medical School and assistant clinical professor of dermatology at the University of Wisconsin Medical School, Madison. He is president-elect of the LaCrosse County Medical Society.

American College of Physicians recently announced the election of new fellows into the College. Wisconsin MDs elected are Robert H Keller, MD, Elm Grove; William A Craig, MD, Madison; and Joseph A Bretza, MD of Shorewood.

American College of Surgeons recently named Badri Ganju, MD* as a fellow in the College. Doctor Ganju is president of Calumet Memorial Hospital's medical staff and a general surgeon at Calumet Medical Clinic. He graduated from the Medical School of Nagpur, India, and served his surgical residency at the Masonic Medical Center, Chicago. ■

GOOD NEWS FOR DOCTORS



If you want a busy practice with no office overhead and little paperwork, then consider becoming a member of the Air Force health care team. You'll find medicine can be a great way of life in the Air Force. We can restore much of the satisfaction to your medical practice because we emphasize patient care instead of paperwork. We even provide professional liability protection under the Federal Tort Claims Act at no cost to you. And your income won't stop should you decide to take your family on vacation. We give you 30 days of vacation with pay each year.

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A great way of life

works well in your office...

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(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

• It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.

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• It helps prevent topical infections, and treats those that have already started.

• It contains three antibiotics that are rarely used systemically.

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NEOSPORIN® Ointment—for the office, for the home.

(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

h gram contains: Aerosporin® (Polymyxin B Sulfate))0 units, bacitracin zinc 400 units, neomycin sulfate g (equivalent to 3.5 mg neomycin base); special white rolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz orox.) foil packets.

RNING: Because of the potential hazard of nephro- city and ototoxicity due to neomycin, care should be rcised when using this product in treating extensive ns, trophic ulceration and other extensive conditions re absorption of neomycin is possible. In burns re more than 20 percent of the body surface is cted, especially if the patient has impaired renal ction or is receiving other aminoglycoside anti ics concurrently, not more than one application a is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

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Research Triangle Park
North Carolina 27709

AN EXCEPTIONALLY FAVORABL

You can expect rapid relief of a broad range of symptoms

With Limbitrol, patients often improve within a week. Not only is insomnia relieved, but you will often see early relief of agitation, psychic and somatic anxiety, anorexia and feelings of guilt or worthlessness. This early response encourages patients to stay in therapy.

You can minimize phenothiazine drawbacks

When you choose Limbitrol over a phenothiazine-containing product, you minimize the risk of tardive dyskinesia — now associated even with low dose, short-term phenothiazine therapy.[1,2] You also reduce the possibility of other extrapyramidal side effects, which occur in approximately 30% of patients receiving phenothiazines.[3-5] In contrast, the reported incidence of these disturbing reactions with Limbitrol or either of its components alone is rare. (For a complete list of side effec reported with Limbitrol, pl consult full disclosure.)

References: 1. Poulson GW *NY State* 79. 193-195, Feb 1979. **2.** Hollister LE Antipsychotic medications and the tre schizophrenia, chap 9, in *Psychopha from Theory to Practice*, edited by Bor *et al* New York, Oxford University Pres pp 134, 145. **3.** Domino EF Antipsyc phenothiazines, thioxanthenes, butyr and rauwolfia alkaloids, chap 25, in *Pharmacology in Medicine*, ed.4, edit DiPalma JR New York, McGraw-Hill Company, 1971, p.476. **4.** Sovner R, Extrapyramidal syndromes and other side effects of psychotropic drugs, in *pharmacology: A Generation of Progre* Lipton MA, DiMascio A, Killam KF Ne Raven Press, 1978, p.1021. **5.** Donl Stenson RL *Dis Nerv Syst 37*: 629-6 1976.

ROCHE®

AFETY/BENEFIT RATIO

What better reason to choose Limbitrol for your patients with moderate depression and anxiety?

Limbitrol® IV

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Efficacy without a phenothiazine

Please see summary of product information on following page.

LIMBITROL® TABLETS Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy*: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy.

Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50.

ROCHE PRODUCTS INC
Manati, Puerto Rico 00701

Your guide to patient management... when you decide medication is needed

How to initiate and maintain therapy

Select dosage strength appropriate for each patient

- Limbitrol 5-12.5 is recommended to minimize drowsiness and for elderly patients
- Limbitrol 10-25 may be indicated for patients who tolerate medication without undue side effects

Specify daily dosage based on symptom severity

- An initial dosage of three tablets is recommended
- Dosage may be increased to six tablets or decreased to two tablets daily as necessary
- Once a satisfactory response is obtained, patients should be continued on the smallest dose required to maintain the desired effect

Utilize dosage options to best accommodate individual patient needs

- T.I.D. or Q.I.D., familiar regimens most suited for patients who tolerate medication without undue drowsiness
- Two tablets one hour before bedtime and one tablet midday may minimize daytime drowsiness and help relieve a common target symptom — insomnia
- Entire dosage h.s. to take maximum advantage of the sedative effect

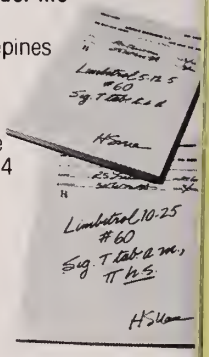
How to make each patient an informed patient

1. Discuss with patients the probability that they will experience drowsiness, especially during the first week.
2. Reassure your patients that drowsiness is one indication that the medication is working and that it may help alleviate their insomnia.
3. Encourage patients to report if drowsiness becomes troublesome so that, if necessary, dosage schedule can be adjusted.
4. Caution patients about the combined effects with alcohol or other CNS depressants. Let them know that the additive effects may produce a harmful level of sedation and CNS depression.
5. Caution patients about activities requiring complete mental alertness, such as operating machinery or driving a car.
6. Warn pregnant patients and patients of childbearing age that the safety of Limbitrol in pregnancy has not yet been established.

Please see complete product disclosure for other pertinent inform

Limbitrol should not be used under the following circumstances:

1. Hypersensitivity to benzodiazepines or tricyclic antidepressants.
2. Concomitantly with an MAO inhibitor. To replace an MAO inhibitor with Limbitrol, discontinue MAO inhibitor for a minimum of 14 days before cautiously initiating Limbitrol therapy.
3. During the acute recovery phase following myocardial infarction.



In moderate depression and anxiety

Limbitrol

Relief without a phenothiazine

Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 35¢ per word, with a minimum charge of $14.00 per ad. BOXED AD RATES: $25.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800-362-9080.

Physicians Exchange

Emergency Medicine. Directorship and clinical positions in low volume emergency department located in the northwestern portion of Wisconsin. Excellent income with additional compensation for director's responsibilities. Paid professional liability insurance, flexible scheduling without on-call involvement. For details contact Frank Siano toll-free at 1/800/325-3982, or send credentials in complete confidence to 970 Executive Parkway, St Louis, MO 63141. 1-3/81

Locum Tenens-CompHealth. Our medical group can place a well-qualified physician in your practice during your absence. For more information call or write: Comprehensive Health Systems, Inc, 175 West Second South, Salt Lake City, UT 84101. Phone: 801/532-1200. 1-2/81

Board certified or Eligible primary care internist and family practitioners for full-time positions in medical school and teaching hospital affiliated community ambulatory care centers. Appointees eligible for faculty appointments. Wisconsin licensure required. Positions available July 1981. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 West Wisconsin Ave, Milwaukee, Wis 53233. Equal Opportunity Employer M/F/H. 1-4/81

Board eligible or Board certified psychiatrist to join group of 49 medical specialists. To work with another psychiatrist, psychologist, and a clinical social worker in both outpatient and hospital environment. The Department covers a broad-based psychiatric practice. Quality medicine close to University Centers. Competitive income. Contact R E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566, or telephone collect 608/328-7000. 1-3/81

Wisconsin locum tenens available. Family practice, can do OB and ER. High productivity. Write: Locum Tenens, 5695 Merry Lane, Excelsior, Minn 55331. Phone: 612/474-4372. p11-12/80,1-2/81

OBSTETRICIANS-GYNECOLOGISTS WANTED

Obstetricians-Gynecologists board certified or eligible wanted to join in practice with obstetrician-gynecologist in a city of 100,000 on Lake Michigan between Milwaukee and Chicago. Excellent schools, medical school affiliation, security of freedom of practice in independent small group. Contact: Elizabeth A Steffen, MD, 734 Lake Ave, Racine, Wis 53404. Phone: 414/637-8311. 6tfn/80

The Nicolet Clinic, SC, a young progressive 33 physician multispecialty group, has superb opportunities available for the practice of:

- Nephrology
- Ophthalmology
- Family Practice
- Radiology

Ideal family oriented community in metropolitan area with excellent schools, economy, culture, and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued medical education. Contact in confidence Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Phone: 414/727-4244. 11-12/80,1-2/81

Relocation opportunities or initial practice in Fox Valley for general internists, family practitioners, and pediatricians. Support of other independent practitioners assured. Excellent schools, recreational area, as well as clinical facilities in JCAH approved hospital. PO Box 801, Neenah, Wis 54956. p11-12/80,1-4/81

Family Practice. General Clinic — Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Emergency Physician needed June-July 1981 to replace vacancy in five physician career oriented group at Madison, Wisconsin's largest emergency service. Great place to work and live. Send CV and will call you. John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 2tfn/81

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We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

8-12/80,1-7/81

Physicians Exchange

continued

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 23-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 2tfn/81

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Orthopedic surgeon wanted to join a primary care/specialty group of 11 physicians in northwestern Wisconsin. Attractive family/recreational area 45 minutes from Twin Cities. Minimum salary guaranteed first year. Contact Tom Halverson, Clinic Manager, St Croix Falls Clinic, Box 739, St Croix Falls, Wis 54024. Phone 715/483-3221. 8tfn/80

Family Physician—Board Eligible/Certified join primary care group of six FPs and 1 GS. Well established, rural setting, preceptor University of Wisconsin, JCHA 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis. 54615. 3tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

FAMILY PRACTITIONERS

Seeking a board certified/eligible family practitioner to join three family practitioners, three general internists, a pediatrician, and a general surgeon in a high quality group practice in northern Wisconsin community. Clinic building adjoins community hospital. Associate membership, then membership affiliation with a large multispecialty medical group 100 miles distant which provides the full spectrum of consulting services and laboratory and administrative support and continuing medical education opportunities. Salary and fringe benefits excellent. Practice experience desirable but not mandatory. This is an excellent opportunity to practice family medicine with skilled colleagues in a small community environment while enjoying a reasonable call schedule, freedom from business administration, and the security of ready access to consulting specialists in all fields. Send curriculum vitae and the names of persons who can be contacted for reference to:

Howard Chatterton, MD
906 College Avenue, West
Ladysmith, WI 54848 2-4/81

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Anesthesiology (2)
- Cardiology
- Family Practice
- Hematology/Oncology
- Otolaryngology

Beautiful new building adajacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

Cardiologist or internist with an interest in cardiology for Twin Cities Internists Group. CCU, EKG lab, and resident teaching responsibilities. Cath lab available. Position requires necessity to deliver some general medical care. Curriculum vitae and references mailed to Dept 486 in care of the Journal. 12/80, 1-2/81

Fort Wayne, Indiana—Emergency Department Physicians. American Medical Services Association, Inc, a Kansas City based multiple hospital physician group, is seeking career oriented primary care and emergency care physicians who are:

1. Board eligible or certified
2. Show an affinity for the team concept of medical practice
3. Business oriented
4. Show professional maturity and judgment
5. Have a keen desire to succeed
6. Committed to CME

We are successful because we offer the unique package of salary and benefits in the healthcare industry. All of our physicians participate in the ownership of the company. If you feel qualified we are interested in you. Contact: Michael P Colucci, Vice-President of Marketing and Recruitment, American Medical Services Association, Inc, 4400 Broadway—Suite 306, Kansas City, Missouri 64111, 816/931-3040. 2-4/81

Emergency Occupational physician needed for Milwaukee's first free-standing Emergency Care Facility. Please contact: J Gennrich, MD, 8024 N 76th St, Milwaukee, Wis 53233. 414/355-3100. 2/81

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN

MEDICAL PROFESSIONAL PLACEMENTS

5222 Painted Post Drive
Madison, Wisconsin 53716
(608) 222-2927

Licensed Employment Agency 9tfn/79

Wanted. Board certified or eligible oncologist to practice in conjunction with an 8-member medical department in a 22-member multispecialty group. Present sub-specialties: gastroenterology and cardiology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Pediatrician: Join an 18 physician multispecialty clinic in Appleton, Wisconsin. Have departments in Pediatrics, Surgery, Family Practice, Internal Medicine and OB/GYN. Need another pediatrician. Excellent hospitals, guarantee and incentive compensation. Complete benefit package. Medium size community with excellent educational, cultural, recreational, and shopping opportunities. Contact Art Schuetze, Medical Arts Clinics, SC, 401 North Oneida St, Appleton, Wis 54911. Telephone 414/739-0171. 1-3/81

Wanted: Family or General practitioner who does obstetrics to join well-established medical group. Complete clinic facilities and full hospital privileges. Liberal educational and vacation time. Guaranteed salary and opportunity for early partnership. Contact R E Jensen, MD, Rose-Jensen-Sanan, 621 E Walnut St, Green Bay, Wis 54301. Phone: 414/437-4366. 2-4/81

The Fond du Lac Clinic, SC, a multispecialty group of 26 physicians has an opportunity available for a fourth pediatrician. Negotiable salary with full benefits and full partnership available after one year. Contact Kirk A Veit, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, Wis 54935. p2-4/81

Family Practice. Wanted a family practitioner to locate in new clinic building in Poynette, Wis. Located 30 miles from Madison, Wis. Poynette is a village of approximately 1000 with a service area of 7000 persons. Salary guaranteed. Contact John Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 10tfn/80

Racine Medical Clinic, SC, multispecialty group of 20 physicians has a practice association for:

- General Surgeon

The Clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, SC, 5625 Washington Ave, Racine, Wis 53406. 414/886-5000. 9tfn/80

Grow with us in sunny Arizona. The INA Healthplan needs physicians in family practice and most specialties in Tucson and Phoenix. Competitive salaries and comprehensive benefits including a professional development program, retirement plan, and group incentive bonus are provided. If team interaction and casual living interest you, send your CV to: Professional Relations, INA Healthplan, Inc, 6115 North 7th St, Phoenix, AZ 85014. 12/80, 1-2/81

Family Practitioner. An excellent family practice setting is available in Green Bay, Wis. Individualized practices, and coverage reciprocity. New 165-bed family practice hospital under construction. Write: Physicians in Family Practice, 120 Siegler St, Green Bay, Wis 54303. Tel: 414/497-0707. p2-3/81

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multi-specialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Board certified or eligible family practitioners, OB-GYN and surgeon wanted to join expanding multispecialty group located in South Central Wisconsin near major metropolitan area. Excellent salary structure and benefits first year with options thereafter. Interested physicians inquire immediately. All requests to be answered immediately and in confidence. Write Dept 488 in care of the Journal. 2/81

Immediate opening for general and child psychiatrist to join well established clinic in a community of 50,000. Large referral area. Two excellent hospitals. University and industrial area. Salary open. Excellent benefits. Contact: J M Tobin, MD, Northwest Psychiatric Clinic, Box 224, Eau Claire, Wis 54701. Phone: 715/834-2751. 12/80, 1-2/81

General Surgeon, July 1981, to join the Wilkinson Clinic, SC, a multispecialty group of 16 physicians located in lake country between Milwaukee/Madison. Excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: David O Ulery, MD, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066. 414/567-4433. 2tfn/81

Physician wanted to perform light physicals five days per week in the Milwaukee area. Ideal job for retiring physician. Contact Mike Stough, collect, at 513/621-8728. 11tfn/80

Medical Facilities

For Sale. Dictaphone, think tank and transcriber—excellent condition. Phone: 414/457-4438. 1tfn/81

FAMILY PRACTITIONERS

Seeking a board certified/eligible family practitioner to join family practitioner and general internist in a high quality growing practice in northcentral rural Wisconsin. Modern clinic building adjoined to community hospital. Call shared with two other physicians in a nearby community. Associate membership, then membership affiliation with a large multispecialty medical group 60 miles distant offering the full spectrum of consulting services and providing laboratory and administrative support and continuing medical education opportunities. Salary and fringe benefits excellent. Practice experience desirable but not mandatory. This is an excellent opportunity to exercise your talents in adult medicine, pediatrics and OB-GYN in a small community environment practicing with skilled colleagues while enjoying a reasonable call schedule, freedom from business administration, and the security of ready access to consulting specialists in all fields. Send curriculum vitae and the names of persons who can be contacted for reference to:

Frederic Wesbrook, MD
Marshfield Clinic
1000 North Oak
Marshfield, WI 54449 2-4/81

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

For Sale: Biodynamic Digitek, Coagulation Unimeter 500, Environmental Chamber, Burdick EK III with stand, exam table, cast cutter, 2 overhead surgery lamps and Mercury Manometer. X-ray cassettes, developing tank and film storage bin. In addition to the above injectables, paper products, lab accessories and other expendables will be sold at half our cost. Contact Henry A Settlage, MD, Box 280, Crivitz, Wis 54114. 2/81

For Sale: Zeiss Photomicroscope with circular rotating and centering mechanical stage, automatic exposure device and full power pack. Several objective and ocular lenses. Excellent condition. Regularly maintained by manufacturer's representative. Contact Mr. Bernard Goldstein, 606 West Wisconsin Ave, Milwaukee, Wis 53203. Phone: 414/271-1400. g10tfn/80

FOR RENT office space Greater Milwaukee area. 750-1500 sq ft in prestigious 3-year-old medical building located on Northridge Lakes (7400 West Brown Deer Road) only minutes from Northridge. Opportunity for medical group, specialist, or satellite office. Will remodel to suit. Please call area code 414/354-1160. 12tfn/80

Associate Medical Director

One of Chicagoland's largest manufacturing plants is seeking a physician for its staff.

This plant's Medical Department has a staff of four (4) physicians, including a director, participating in a comprehensive program of occupational medicine in a well equipped and modern medical facility.

Opportunities for professional growth and advancement are excellent.

The Medical Department includes a fully staffed complex with an x-ray unit, laboratory and clinic facility. It has a full range of medical activities including traumatic preplacement and consulting services. It also includes an Occupational Hygiene Division having a comprehensive program for evaluation of environmental exposure.

An outstanding company paid fringe benefit package is included. Salary available is open depending upon the candidate's experience.

Normal working hours are 8:00 A.M. to 5:00 P.M. Monday thru Friday. A wide variety of desirable locations in which to live are available.

Reply in confidence to:
DEPT 487 in care of the Journal
equal opportunity employer m/f

Ritter ENT Unit. Includes motorized chair, service unit with air and suction and cautery and air pump. Also sterilizer with cabinet available. Good condition. Reasonable. PO Box 325, Stevens Point, Wis 54481. Phone: 715/341-2020. 2tfn/81

Practice of General Practitioner available in Whitewater, Wisconsin. Older physician who must retire for health reasons. Can take over office with reasonable appraisal of equipment. Three GPs and one osteopath in community with UW campus and small industries. Convenient between Milwaukee and Madison. Hospital 9 miles away in Fort Atkinson. College Health Center may desire part-time assistance. Immediate responses needed. Phone 414/473-2121, or 414/473-5171. *2-3/81

Allied Health Services

Registered Occupational Therapist looking to work full or part time with a private physician. Masters degree plus four years clinical experience including arthritis, hand rehabilitation, orthopedics, and neurology. Experience in splinting. Please contact Susan Fishbach, MS, OTR, 3909 North Murry Ave, Shorewood, Wis 53211. 414/332-8951. 2/81

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Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of poblication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1980 through Aug 31, 1981.

WISCONSIN

MARCH 1-2, 1981: *5th Annual Winter Pediatric Seminar,* Caribou Lodge, Powderhorn Ski Area, Bessemer, Mich. Approved for 8 credit hours of Category I of the AMA-PRA and AAFP. Fee: $55. Info: Marshfield Clinic, Office of Medical Education, 1000 North Oak Ave, Marshfield, Wis 54449.

MARCH 12, 1981: *Infection Control for Community Hospitals and Extended Care Facilities,* University of Wisconsin Clinical Science Center, Madison, Wis. Sponsored by Infection Control Unit, Dept of Medicine, University of Wisconsin; and University of Wisconsin-Extension, Continuing Medical Education. Approved 10 credit hours of Category I of AMA; Continuing Education Units, University of Wisconsin-Extension—1 unit. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

MARCH 19-20, 1981: *5th Annual Ophthalmology Current Concepts Seminar '81,* Sheraton Hotel, Madison. AMA Category I on an hour-by-hour basis. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

APRIL 9-10, 1981: *7th National Conference on Case Resolution of Complex Industrially Injured,* Pioneer Inn, Oshkosh, Wis. Sponsored by Industrial Injury Clinic, University of Wisconsin-Extension, Continuing Medical Education, in cooperation with Theda Clark Regional Medical Center. AMA Category I, Continuing Legal Education credits, Commission on Rehabilitation Counselor Certification, University of Wisconsin Continuing Education units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

APRIL 9-11, 1981: *Coronary Heart Disease 1981,* presented by St Luke's Hospital and St. Luke's Hospital Foundation, Inc, at Hyatt Regency Milwaukee, in Milwaukee. Meets criteria for 16 hours in Category I of PRA-AMA; also acceptable for 16 prescribed credit hours by AAFP. Fee: $250, payable to: St Luke's Hospital, and sent to: Mrs Dorothy Black, Public Relations Dept, St Luke's Hospital, 2900 W Oklahoma Ave, Milwaukee, WI 53215.

APRIL 24, 1981: *Perspectives in Diabetes Mellitus—1981,* Madison. Approved 7 credit hours AMA and LCCME Category I, Family Practice credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

APRIL 22-24, 1981: *The Geriatric Patient,* Inn on the Park, Madison. Sponsored by the Extension Services in Pharmacy, in cooperation with the School of Pharmacy, University of Wisconsin, Madison. The conference will explore economic, physiological, psychological and social aspects of aging along with numerous therapeutic issues. Extension Services in Pharmacy has accredited the conference for 14 continuing education hours (1.4 CEU's). In addition, the conference is acceptable for 14 credit hours in Category I of AMA-PRA. Info: Alan L Hanson, PhD, Extension Services in Pharmacy, School of Pharmacy, 425 N Charter St, Madison, Wis 53706, or call 608/262-3130.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1981-1992

Meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) with the Marc-Plaza as the headquarters hotel. Starting in 1982, the new Hyatt Regency will be the headquarters hotel.

1981—March 26-28	**1987—March 26-28**
1982—May 13-15	**1988—April 28-30**
1983—March 24-26	**1989—April 13-15**
1984—March 29-31	**1990—April 26-28**
1985—March 28-30	**1991—April 18-20**
1986—April 17-19	**1992—April 23-25**

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Toll free number 1-800/362-9080.

April 9, 10, 11, 1981
Hyatt Regency Milwaukee

PRESENTED BY

St Luke's Hospital and St Luke's Hospital Foundation, Inc

CORONARY HEART DISEASE—1981 will be a unique gathering of scientific and practical knowledge to update cardiologists, internists, cardiac and thoracic surgeons and family practitioners on the assessment and care of the cardiac patient with obstructive coronary disease.

Included will be discussions of the causes of atherosclerosis and factors influencing the regression and progression of the disease; medical and surgical treatment of severe obstructive disease; the latest approaches in rehabilitation; management of power failure, heart block, and rhythm disturbances in relation to acute infarction.

There will also be an update for surgeons on techniques and devices, information on diagnostic techniques, including nuclear medicine, echocardiography and pacemakers, and a special session on transluminal coronary angioplasty.

Information from matched and randomized studies will be presented, and a *ten*-year update of bypass surgery results by four internationally recognized heart centers—Cleveland, Milwaukee, Montreal, and Texas—will be presented for the first time nationally.

ACCREDITATION: St Luke's Hospital is accredited for issuing continuing medical education. This symposium meets the criteria for 16 hours in Category 1 of the Physician's Recognition Award of the AMA. This program also is acceptable for 16 prescribed credit hours by the AAFP.

REGISTRATION AND FEE: $250 includes all registration materials, lunches, refreshment breaks, and one ticket to the Gala Museum Party (April 9). Reduced fee of $125 to limited number of nurses, residents, and fellows. Check payable to: St Luke's Hospital. Send to: Mrs Dorothy Black, Public Relations Dept, St Luke's Hospital, 2900 W Oklahoma Ave, Milwaukee, WI 53215.

PRESENTED IN COOPERATION WITH: American Academy of Family Physicians, American Heart Association/Wisconsin Affiliate, American Heart Association Council on Clinical Cardiology, American College of Physicians, American Heart Association Council on Cardiovascular Surgery.

APRIL 28, 1981, Green Bay; APRIL 29, Wausau; APRIL 30, Eau Claire: *Suicide Assessment and Intervention.* Sponsored by Allied Health Program Unit, University of Wisconsin-Extension; and Continuing Education in Mental Health, University of Wisconsin-Extension. Approved 6 hours of University of Wisconsin Continuing Education credit. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

MAY 1, 1981: Second Annual Professional Institute, *Guilt,* sponsored by the Department of Psychiatry, Mount Sinai Medical Center, at Sheraton Mayfair Hotel, 2303 North Mayfair Rd, Milwaukee, Wis. Approved 6 credit hours of Category I of AMA-PRA. Info: Bella H Selan, MS, Mount Sinai Medical Center, Outpatient Psychiatry Clinic, 950 North 12th St, Milwaukee, Wis 53233.

MAY 1-2, 1981: *Trends in Radiologic Technology—1981,* Wisconsin Center, Madison, Wis. Sponsored by Allied Health Program Unit, University of Wisconsin-Extension; and Department of Radiology, School of Medicine, University of Wisconsin, Madison. ECE points applied for from ASRT; University of Wisconsin Continuing Education Units.Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

MAY 4-6, 1981: *Intravenous-Arteriography.* University of Wisconsin-Madison, Memorial Union, Madison. Approved 16 credit hours Category I and 16 hours American College of Radiology. Fee: $395. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706. Phone: 608/263-2856.

MAY 6-8, 1981: *4th Annual Cardiac Rehabilitation Symposium,* Red Carpet Inn, Milwaukee, Wis. Sponsored by University of Wisconsin-Extension, Continuing Medical Education; Mt Sinai Medical Center, Milwaukee, American Heart Association. Approved 21 hours AMA Category I, 2.1 University of Wisconsin continuing education units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

MAY 8, 1981: Second Annual Professional Institute, *Obesity,* sponsored by the Department of Psychiatry, Mount Sinai Medical Center, at Sheraton Mayfair Hotel, 2303 North Mayfair Rd, Milwaukee, Wis. Approved 6 credit hours of Category I of AMA-PRA. Info: Bella H Selan, MS, Mount Sinai Medical Center, Outpatient Psychiatry Clinic, 950 North 12th St, Milwaukee, Wis 53233.

MAY 15, 1981: Second Annual Professional Institute, *Late Life Care,* sponsored by the Department of Psychiatry, Mount Sinai Medical Center, at Sheraton Mayfair Hotel, 2303 North Mayfair Rd, Milwaukee, Wis. Approved 6 credit hours of Category I of AMA-PRA. Info: Bella H Selan, MS, Mount Sinai Medical Center, Outpatient Psychiatry Clinic, 950 North 12th St, Milwaukee, Wis 53233.

JUNE 4-6, 1981: *Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias,* The Performing Arts, Milwaukee. Approved 18 credit hours of Category I of PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

JUNE 11-12, 1981: *Neurological Intensive Care Symposium,* Wisconsin Center, Madison, Wis. Sponsored by Continuing Medical Education, University of Wisconsin-Extension; and Division of Neurological Surgery, School of Medicine, University of Wisconsin, Madison. Approved 17 hours AMA Category I; 1.7 continuing education units, University of Wisconsin-Extension. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

JUNE 25-27, 1981: Annual Meeting of the Wisconsin Academy of Family Physicians, Hyatt Regency Hotel, Milwaukee. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

UPPER MIDWEST

MARCH 13-14, 1981 (Illinois): *Practice Management of Common Geriatric Problems,* Rush-Presbyterian-St Luke's Medical Center, Chicago, Ill. Approved 14 credit hours of AMA and LCCME Category I. Info: Maria Gonzales, Office of Continuing Education, Rush-Presbyterian-St Luke's Medical Center, 600 South Paulina St, Chicago, Ill 60612. Phone 312/942-7095. 1-3/81

MARCH 18-20, 1981 (Illinois): *Scientific Aspects of Neurology,* Continental Plaza, Chicago, Ill. Sponsored by Rush-Presbyterian-St Luke's Medical Center. Approved 22 credit hours of Category I of AMA-PRA. Info: Maria Gonzales, Office of Continuing Education, Rush-Presbyterian-St Luke's Medical Center, 600 South Paulina St, Chicago, Ill 60612. 312/942-7095. 2/81

MARCH 19-20, 1981 (Iowa): *4th Annual Meeting Health Care in the Elderly.* Sponsored by the University of Iowa Departments of Family Practice and Internal Medicine and the Iowa Gerontology project. Approved 15½ credit hours of Category I of AMA-PRA. Visiting speakers are MDs Alex Comfort, UCLA; David Bentley, University of Rochester; Maurice Schnell, East Carolina Medical School; and James Patee, University of Minnesota. Info: Ian M Smith, MD, Department of Internal Medicine, University of Iowa Hospitals, Iowa City, Iowa 52242, 319/356-2727.

APRIL 30-MAY 2, 1981 (North Dakota): Annual Meeting, North Dakota Medical Association, at Jamestown. Info: V E Wagner, Exec Sec, PO Box 1198, Bismarck, ND 58501.

APRIL 30-MAY 5, 1981 (Kansas): Annual Meeting, Kansas Medical Society, at Salina. Info: J Slaughter, Exec Dir, 1300 Topeka Ave, Topeka, KS 66612.

MAY 1-2, 1981 (IOWA): American College of Physicians Meeting, University of Iowa, Iowa City. Info: William B Galbraith, MD, 115 Eighth St NE, Cedar Rapids, IA 52401.

MAY 3-6, 1981 (Nebraska): Annual Meeting, Nebraska Medical Association, at Lincoln. Info: K E Neff, Exec Dir, 1512 First National Bank Bldg, Lincoln, NE 68508.

MAY 20-22, 1981 (Minnesota): Annual Meeting, Minnesota State Medical Association, at Minneapolis. Info: H W Brunn, Exec Vice-pres, 2221 University Ave SE, Suite 400, Minneapolis, MN 55414.

OTHERS

APRIL 4-8, 1981 (Washington, DC): Thirty-seventh Annual Congress of the American College of Allergists, at the Sheraton-Washington Hotel, Washington, DC. Credit for Category I, Continuing Medical Education, for the AMA's Physician's Recognition Award will be granted on an hour-for-hour basis. No registration fee for fellows or residents in allergy training, or for nurses in allergy programs presenting letters from department heads of teaching hospitals. Info: Shirley Schoenberger, Exec Secy, American College of Allergists, 2141 Fourteenth St, Boulder, CO 80302; (303) 447-8111.

APRIL 21-23, 1981 (Washington, DC): *Technology Assessment Forum on Coronary Artery Bypass Surgery: Economic, Ethical, and Social Issues,* sponsored by the National Center for Health Care Technology in collaboration with National Heart, Lung and Blood Institute, National Institutes of Health, at Sheraton Washington Hotel, Washington, DC. Info: Michael Eliastam, MD, Special Assistant to the Director, National Center for Health Care Technology, Parklawn Bldg, Room 17A-29, 5600 Fishers Lane, Rockville, Md 20857; (301)443-4097.

MAY 16-20, 1981 (Ohio): Annual Meeting, Ohio State Medical Association, at Cleveland. Info: H F Page, Exec Dir, 600 S High St, Columbus, OH 43215.

JULY 30-AUGUST 2, 1981 (Ohio): *International Doctors in Alcoholics Anonymous, Annual Meeting.* Hotel reservations directly at Cleveland Marriott Inn/Beachwood, 3663 Park East Drive, Beachwood, OH 44122 or call 216/464-5950 or 800/228-9290. (Be sure to specify IDAA for special rates). Further information contact Secretary IDAA, 1950 Volney Rd, Youngstown, Ohio 44511. Phone: 216/782-6216.

AMA—1981

JUNE 7-11: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 6-9: Interim AMA House of Delegates, Las Vegas Hilton, Las Vegas, Nev.

AMA—1982

FEBRUARY 25-28: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8: Interim AMA House of Delegates, Fountainbleu Hilton, Miami, Fla. ■

State Medical Society of Wisconsin

SCANDINAVIAN HOLIDAY

June 27-July 11, 1981

A unique holiday to the land of the midnight sun—Scandinavia is now being offered to physicians and their friends through a special tour being arranged by the State Medical Society of Wisconsin and Dittmann Tours, Inc. The two-week tour will highlight the many faces of Scandinavia—the mountain and fjord scenery of Norway, the enchanting countryside of Denmark and Sweden's folklore rich provinces.

Cost: $1,998, round trip Milwaukee or Madison to New York to Copenhagen with return from Stockholm via Northwest Orient Airlines. Reserve space for $150 and final payment due on April 25, 1981.

Info: Dittmann Tours, Inc, PO Box 199, Northfield MN 55057 or contact Lee Johnson, State Medical Society of Wisconsin, toll free number 1-800-362-9080.

News You Can Use

By EARL THAYER, Secretary / BERNIE MARONEY, Assistant Secretary

PHYSICIANS REMINDED OF CONTROLLED SUBSTANCES LAWS. "Many Wisconsin doctors who are dispensing Controlled Substances are in violation of Federal and State laws," the State Division of Enforcement has charged. In late December the Division, which is part of the State Dept of Regulation and Licensing, told the Medical Examining Board that many doctors are committing "technical violations" in the areas of improper record-keeping, inadequate security controls, and clinics ordering under one doctor's DEA (Drug Enforcement Agency) number with all doctors in the clinic dispensing the substance. In most cases the Division said there is not any illicit use of the controlled substances but there are technical violations which could result in fines of up to $25,000 and in some cases jail sentences. In a related matter the Division reminded the Medical Examining Board that physicians desiring to use marijuana to treat terminally ill cancer patients and glaucoma patients, must be authorized by the Federal Drug Enforcement Agency or the Controlled Substances Board. Any other use of marijuana at this time without permission is in violation of the law. Watch for further details in a forthcoming issue of *WMJ*.

BLUE CROSS-BLUE SHIELD SETS 9% FEE CEILING. Blue Cross-Blue Shield United of Wisconsin announced December 10 that it was setting a 9% limit on physician fee increases for 1981. Leo E Suycott, president of Blue Cross-Blue Shield United was quoted in the *Milwaukee Sentinel* as stating that from December 1977 through December 1980, the CPI will have increased by a projected 38.3%, while physician fee levels set by the carrier will be about 25.5%—almost 13% lower than the CPI. He pointed out that not all physicians uniformly increase their charges. "Many physicians maintain the same fee level for two or three years at a time, thus it is difficult to predict whether the entire 9% guideline will actually be implemented by physicians. It could be substantially less," he said.

WISCONSIN MALPRACTICE STATISTICS. The average malpractice award for a physician claim in Wisconsin was more than 20% lower than the national average from July 1975 through December 1978, according to a study done by the National Association of Insurance Commissioners. The average award in Wisconsin was $19,286 compared to $25,161 nationally. During that same period, 47% of Wisconsin physician claims resulted in payment compared to 37% nationally. This 10% difference may be attributable to the success the Wisconsin Patients Compensation Panels have had in limiting the number of frivolous lawsuits in the state. This is suggested by the fact that total claims per 100 physicians were 3.79 in Wisconsin, as compared to 3.83 nationally.

24-HOUR LIMIT ON DEATH CERTIFICATE COMPLETION. The State Medical Examining Board reminds physicians of a recent change to Chapter 69 of the *Wisconsin Statutes,* which requires a death certificate to be completed within 24 hours after death. When the cause of death cannot be determined immediately, a "pending" certificate should be completed to allow the funeral director to file the record, obtain a burial permit, and proceed with the disposition of the remains. When this procedure is not followed, the funeral director should seek assistance from the coroner or medical examiner who is empowered to investigate the death. The Medical Examining Board is referring all complaints to the Division of Enforcement in the Department of Regulation and Licensing and disciplinary action could result if physicians violate this section of the *Statutes.*

SCHWEIKER NEW SECRETARY OF DHHS. President Reagan's Secretary of the Dept of Health and Human Services (HHS) is Sen Richard Schweiker (R-Pa). Schweiker, who was the ranking GOP member of the Senate Labor and Human Resources Committee and the Senate Labor and HHS Appropriations Subcommittee, has opposed national health insurance plans proposed by Sen Edward Kennedy and the Carter administration. The new secretary is a sponsor of a "pro-competition" healthcare plan that would let beneficiaries choose from the private sector insurers and would require employers to include catastrophic coverage in policies offered to employees. ■

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WISCONSIN MEDICAL JOURNAL

MARCH 1981

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APR 17 1981

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Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference poir

These current issues, involving patient compliance or dependency proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for m Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been abl to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have don without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experien you'll come away with a confirmation of your knowledge that I *am* a sa and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/ Roche) Ⓒ, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
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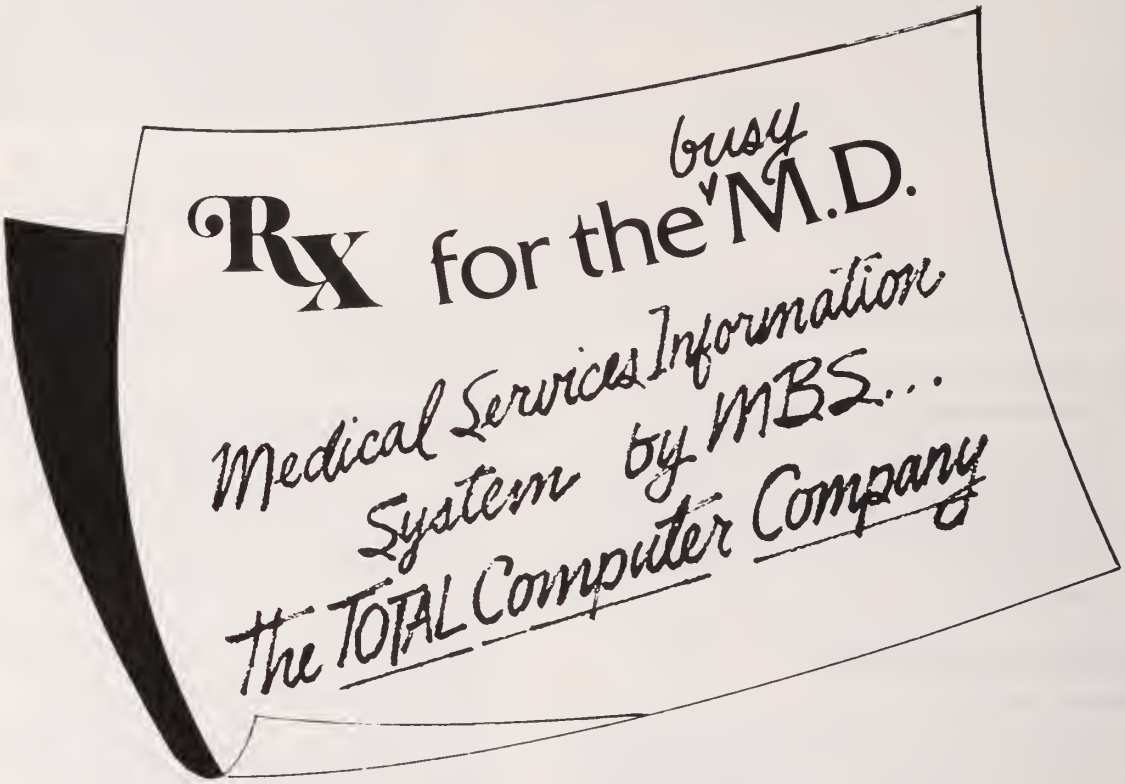

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President's Page

Russell F Lewis, MD

Deductibles and co-payment

DEFINITIONS:

(1) *Deductibles*—A specific amount paid by the enrollee before the insurer will begin to pay benefits—$5.00 for an office visit, $50.00 for hospitalization, for example.

(2) *Co-insurance*—Enrollee pays a specific percentage of the total bill after the deductible, if there is one. For example, many co-insurances call for the insurance company to pay 80% with the enrollee paying the other 20% out-of-pocket. To protect the enrollee there is usually a fixed maximum amount, such as $2,000. Beyond that the insurance company will pay all costs.

(3) *First-dollar coverage*—The insurance company pays 100% of all medical or hospital bills. There may be a few exceptions, such as extra for private room, but in essence the patient receives no bill, no statement, has no idea of the cost of care rendered a majority of times under this program. This has been an attraction of HMOs, because most of them, though not all, have provided first-dollar coverage.

PROBLEM:

It has become fashionable for most medical society leaders, business, industry, and to some extent now, government officials to follow the line that the costs of care are getting out of hand because so many people don't realize the impact inflation has had on the cost of delivering medical care. There is a very strong move afoot to insist on personal accountability for some portion of the bill, with the expectation that not only will the educational process be worthwhile but also will reduce the cost of care because it will make people think twice about costs and utilization patterns.

Philosophically this is diametrically opposed to the position that we in organized medicine have followed through the years. We have urged annual or regular examinations and prompt reporting of any abnormal symptoms or signs so that the disease process may be picked up as early as possible and treated early enough to have an impact on the cost of care. This was felt to avoid, in many cases, serious complications with prolonged expensive hospital and other medical procedures. At a recent State Medical Society HMO meeting in Madison, Dr George Collentine of Milwaukee, a member of the Council on Scientific Affairs for the AMA, stated that originally the members unanimously agreed that this utilization of co-payment and deductibles was necessary to help contain costs. However, he stated that during the years as this subject has been thoroughly studied, there has remained unanimous agreement on the part of the members of the Council that adopting this type of program probably would not change the quality of medical care in an effective or desirable manner.

Since this is to be a major approach in the corporate visitation program, and since most of us as private physicians have been espousing this philosophy, it seems appropriate the time has come to take a look at some of the advantages and disadvantages.

PROPONENTS OF CO-PAYMENT AND DEDUCTIBLES CITE THE FOLLOWING ADVANTAGES:

(1) It provides an incentive for both consumers and providers to look at costs and reduce utilization rates. Evidence would seem to indicate that it may, but it doesn't indicate whether the services eliminated were truly unnecessary.

(2) It penalizes the individual who demands more healthcare, particularly when it may not be needed. Therefore, it's more equitable.

(3) It reduces the cost of the insurance premium as it generates money. This is only a short-term saving and may not necessarily be an overall cost containment, transferring the payment from one payor to another. This is particularly applicable, however, in the deductible field and is seriously being considered, as this editorial is written, by the Department of Health and Social Services in the Medicaid program. It is the Department's feeling that if it tacked a 50¢ to a $1.00 charge on prescriptions and a dollar or two for eyeglasses, this would not place those services out of the reach of anybody's pocket-

book and would bring in perhaps as high as $7,000,000 to reduce the load on the state. The major basic difficulty with the deductible approach is that it works only in those areas where services can be controlled. In other words, if somebody has to pay the dollar before they pick up their eyeglasses, or 50¢ before the prescription is given to them, they will pay for it; but if you tack on a $1.00 to $10.00 charge for a physician's office visit, it is in most offices impossible to collect that bill before the services are rendered, and even harder to collect afterwards without spending more money to collect the amount than it costs to collect.

(4) Some people feel the biggest advantage is that it makes the providers become more cost conscious.

DISADVANTAGES TO THE COST SHARING CONCEPT:

(1) For deductibles involving services of physicians, the cost of collection outweighs the money received.

(2) It probably does not reduce unnecessary utilization, especially with a patient in the hospital where during a serious illness the attitude of the patient, the family, and all the providers is to "let's do the best thing for the patient."

(3) There is some evidence that suggests it may reduce ambulatory care, emergency room visit, etc, but it also seems to increase expensive hospitalization later.

(4) Cost sharing tends to discourage the use of preventive care, screening examinations, and many of the things for which HMOs are supposed to stand.

(5) Realistically it's difficult to take away a benefit that has already been obtained by many unions, many HMO members, because once people have had total coverage for major medical benefits they will not, if possible, accept the cost-sharing idea, particularly since it also does away with the predictability of cost of care since enrollees never know what they may have to pay out of their own pocket for these co-payment and deductible portions of their cost.

(6) Perhaps most worrisome to many is that we again get back to a two-tiered structure of health-care, that available to the rich and that available to the poor, because obviously the wealthy can afford to come and utilize as much as they want, but a 20% co-payment may seriously jeopardize proper care in some people.

In conclusion, one must question realistically the basic logic that by making people share in the cost of care they are going to not only know more about what it costs but also are going to be willing to cut back on their particular care. I have yet to find a patient who really is willing to accept this for himself or his family. They are, however, willing to apply this standard to everybody else! It goes against all of the philosophies that we have been proposing for years; and while some of this is important, I believe that a good educational program about the costs of care would do as well in educating the public without jeopardizing their health. This does not mean that there may not be some areas to which the co-insurance principle may not be applied, but I doubt if it's properly applied to actual physicians' services in a satisfactory fashion. ■

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Editorials

WAYNE J BOULANGER, MD, *Editorial Director*

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Itinerant surgery

MANY OLD TIMERS can remember the days when a well-known surgeon would board a train in Madison and travel a hundred miles or so upstate to consult with local physicians in a small town, often operating in the local hospital, and then taking the train back the next day. It was a fine romantic gesture. But with the passage of time, as surgeons have grown more numerous, itinerant surgery has become infrequent. In fact its total disappearance has been anticipated. So it was a bit of a surprise when the newspaper releases appeared announcing the suit brought by the American Academy of Family Physicians against the American College of Surgeons, challenging its stand against itinerant surgery.

The newspaper story stated that a Nebraska surgeon had been disciplined by the ACS because of his penchant for performing surgery outside his home base, and then turning over the postoperative care to the family practitioner-referring physician, a practice which the ACS has long held in disdain. The Nebraska surgeon had actually brought the suit, but the AAFP joined in later on the grounds that family practitioners are perfectly capable of rendering postoperative care, and should not be prevented from doing so.

It is not proper to argue the merits of the specific case here. The courts will decide. Certainly it can be shown that a family practitioner can be trained to render perfectly acceptable postoperative care. The real issue under litigation is whether an organization can be sued for following its own rules and regulations. Every Fellow of the ACS knows that itinerant surgery violates the rules of the College; and when he breaks the rules, he must be prepared to take the consequences.

Legal considerations aside, however, the itinerant surgery question still requires scrutiny. Is there a need for itinerant surgery? If there is no need, can its perpetuation be justified?

With present day methods of transport, there can be very little justification for itinerant surgery on the basis of need, although no one will challenge an occasional emergency exception. So then why is it continued? The answer is obvious. It persists because it is to someone's financial advantage to keep it alive. The local hospital with its low census keeps another bed from being empty, and the referring physician keeps another name on his daily rounds list. An extra week or so of hospital visits adds up to a lot of money, and constitutes a substantial inducement for further referrals as well, all at the expense of the patient and his insurance company.

But what about the patient? If complications develop, are the ancillary services as good as they are in the itinerant surgeon's primary hospital? If the operation carries with it a significant risk, shouldn't the surgery be done in the best possible location? The small hospital is undoubtedly less expensive on a daily room rate basis, but those savings will disappear quickly when problems arise.

In the long run, condoning itinerant surgery will work to the disadvantage of the small hospital. It will keep the young, well-trained specialist from establishing his practice there, because he won't be able to compete with the hit-and-run surgeon unless he offers the same inducement to the referring physician—something his peer group will not allow.

Fee splitting has many forms. Itinerant surgery is certainly one of them, and cannot be condoned.

—WJB

A new farm hazard

ABOUT THREE years ago a 16-year-old farm worker from Eau Claire county died while working in a barn. The case was reported in the January 2, 1981 *JAMA*.

He had been using high pressure hot water to clean manure from gutters inside an empty calf barn. He was working about ten yards from a 100,000 gallon liquid manure storage tank, the contents of which had been agitating for 30 to 60 minutes. After ten minutes he began to cough, vomited, collapsed, and died. Two workers who tried to rescue him became unconscious but recovered.

Modern and energy conscious American farmers are employing more liquid manure systems than ever before. The US Public Health Service and the Wisconsin Division of Health had issued a warning to farm workers involved in the operation of these systems. The danger results from hydrogen sulfide gas given off by decomposing manure. Deaths have also occurred when farm workers have entered recently emptied liquid manure tanks and among animals that were simply exposed to the fumes. The Division of Health advises farm workers to evacuate

all humans and animals from the area surrounding the manure tank before and immediately following agitation. Ventilating systems in buildings housing liquid manure systems should be run at maximum capacity during agitation. Also recommended are self-contained air packs and backup help for workers who must enter closed spaces containing manure tanks. There also are some cases reported of individuals drowning after falling into full tanks of liquid manure.

Exposure to low concentrations of hydrogen sulfide causes headaches, eye, nose, and throat irritations, cough, nausea, and dizziness. One treacherous thing is that the gas rapidly lessens the sense of smell so the odor may not be an entirely reliable warning.

The hazard of liquid manure tanks is something of which physicians in rural Wisconsin should be aware.—VSF

Round we go

RECENTLY A YOUNG surgical resident returned from a trip to Germany. He had been awarded the trip for submitting the winning paper on trauma.

In reporting his trip,[1] he wrote that he had met with several attending trauma surgeons and "rounded on their patients." Later, he had the opportunity "to round with an attending cardiac surgeon."

The tendency to create verbs from nouns has been particularly prevalent in medical writing. Nodes are biopsied, the deceased are autopsied, and now patients are rounded.

I'll go along with round eyes, round heads, round figures, and round heels, but rounding on patients—never!—VSF

1. *Bulletin of the American College of Surgeons*, October, 1980. ■

Healthcare

Health Division starts new drive to increase rubella immunization

WOMEN CONTINUE to risk giving birth to infants with Congenital Rubella Syndrome (CRS) because they are not immunized, according to a study by Illinois researchers (*JAMA*, January 23, 1981).

The Chicago-area study involving hospitals and physicians was started in 1978 when physicians began seeing infants with symptoms of CRS (cataracts, glaucoma, cardiac defects, hearing impairments, and mental retardation) after a major outbreak of rubella.

A survey of area hospitals disclosed 30 infants with symptoms of CRS, compared to 40 reported yearly for the nation as a whole. Only 8 of the 30 infants with CRS had been reported to local health authorities.

Interviews with the mothers showed that none had been immunized against rubella. Twenty of the 30 women were unmarried, and so were not reached by premarital screening. The two-thirds with no previous births were also missed by programs which immunize susceptible mothers after they give birth.

The last reported CRS case in Wisconsin (January 1980) was a 3-month-old female born to a 16-year-old Wausau-area unwed mother with no history of immunization.

In 1979 the highest incidence of rubella was in persons 15-19 years of age, followed by persons 20-24 years of age. The 15-20 percent seronegativity rates and continued rubella incidence among those in the childbearing age are not attributable to waning immunity but to lack of immunization.

Unimmunized hospital and clinic personnel are at risk to contracting rubella from infants with CRS who continue to shed virus for an indefinite period. Infected employees can also pass the disease on to their unimmunized patients, some of whom might be pregnant women. Recent cases of nurses becoming infected from CRS infants were reported from North Dakota, Alabama, and Ohio.

The Division of Health urges that serologies be done on all patients of childbearing age, followed by immunization of the susceptibles if they are *not pregnant* and are *not planning to become pregnant* for at least three months following immunization.

Postpartum immunization of susceptibles is advised. Employees should be screened for rubella immunity and the susceptibles immunized.

Any actual or anticipated CRS births should be reported to the nearest health agency or the Division of Health, 608/266-2346, collect. ■

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Some thoughts on second opinion

STARTING February 1, second opinions must be obtained for 11 surgical procedures as a condition for payment under Medicaid.

Physicians should know that the Legislature, not DHSS, mandated this program. Most of us, including the Department, have serious doubts that it will save money in Wisconsin. Nevertheless, the lawmakers cut $500,000 from the current DHSS budget and told DHSS Secretary Donald Percy to save that amount through a program of second opinion. Mr Percy understandably chose not to ignore the Legislature's directive.

Since early last November the Society's officers, staff, and Medicaid Medical Audit Committee have had intense and repeated dialogue with the Department on how best to implement a program which we felt at best was full of problems. We were able to make important changes for the better in what the second opinion doctor could do and the charges permitted for that service.

We have agreement from the Department that it will carefully track *all* expenses related to the second opinion program including subsequent medical or surgical care for patients who choose not to go through with the originally proposed surgery.

At least the Legislature had the good sense to put a sunset provision on the program. It will expire on July 1, 1982, unless reenacted by the Legislature after an evaluation.

As doctors we have always recognized the right of a patient to consultation or second opinion. Mandating second opinion is something else. We must always act to protect the well-being of our patients. When in our best judgment the patient must be operated as an urgent or emergency matter, we have no other choice. SMS must and will step in whenever needed to argue that case with DHSS.

I am very concerned that mandatory second opinion forces many of us to treat Medicaid patients differently than other patients. Up to now in my practice I have not known when the patient I was treating was on Medicaid. Now I must request that they tell me whether they are on medical assistance. This can be embarrassing and upsetting for them and our relationship.

Second opinion will obviously create some bizarre situations of inconvenience, delay, pain or discomfort, and needless expense, especially in rural areas and towns with only one practitioner in a surgical specialty.

The Department can waive the second opinion in individual cases. If the waiver is widely used, the program becomes a sham. If the waiver is not used, there could be real hardship, perhaps even harm to some patients.

continued►

Points to remember about second opinions

CHECK ELIGIBILITY—Be sure to check the *current* MA card of the Medicaid recipient. These change every month. Some recipients are on and off Medicaid. The second opinion process may take from one week to several weeks. The patient may have been *on* Medicaid when the first surgical opinion was provided, but may be *off* Medicaid by the time the second opinion is received. Be sure to check eligibility just before going ahead with the surgery.

BILLING FOR FIRST OPINION SERVICES—Under the new Second Opinion program, it is conceivable that long delays can occur between the time surgery is first recommended and the go ahead is authorized after a second opinion. In some cases the patient may never return for surgery. Physicians or their business offices should consider routine and prompt billing to Medicaid (EDS) for the services associated with the examination and workup leading to the first recommendation for surgery.

BILLING FOR SECOND OPINIONS—Misleading instructions for billing second opinion services were provided by a January 19, 1981 Medicaid Bulletin from EDS. The "correct billing example" on the reverse side of the EDS bulletin erroneously implies that second surgical opinion examinations should be billed as CPT-4 code 90000 "new patient—brief service-second surgical opinion examination." In fact, the rules of second opinion permit the second opinion physician to perform and bill for "an examination sufficient to determine the appropriateness of the proposed elective surgery and the potential medical risk." Contrary to the implication of the Bulletin, the second opinion physician may perform and bill for more than a "brief service" if that is indicated to provide an adequate examination. If there are problems on these issues, the physician should contact the SMS Physicians Alliance office at Madison: 608/257-6781 or toll-free 1-800-362-9080.

Each of us, with our State Society, must inform Medicaid patients that this invasion of their privacy and associated delays and inconvenience are the result of legislative regulation, not medical necessity. We also have an obligation while participating in this 18-month experiment to be candid with our patients, our legislators, and the Department about all aspects of the program, both favorable and unfavorable.

Russell F Lewis, MD, President
State Medical Society of Wisconsin

Physician's Assistant

I READ WITH interest Mr Bauer's commentary regarding the closing of the Physician's Assistant Program in Marshfield (*WMJ*, October 1980). There is an implication that something was not disclosed about the reasons for this action. The only thing that comes to mind is the inability of the Marshfield Medical Foundation and the University of Wisconsin to merge the two PA programs; while not playing a major role in my decision-making process, this was of some consequence. I would remind Mr Bauer that there is a Physician's Assistant Program presently operating at the University of Wisconsin. I personally still strongly support the PA concept as long as the state guidelines are closely followed; most especially those relative to independent practice of those other than a physician.

The decision was difficult but, I believe, based on realistic observations. Only time will prove either of us correct.

Richard D Sautter, MD
Executive Director
Marshfield Medical Foundation
Marshfield, Wisconsin ■

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What physicians should know about the Wisconsin WIC Program

THE WISCONSIN Women, Infants, and Children's Program (WIC) is a preventative health and nutrition program which helps pregnant and postpartum women, infants, and children maintain proper nutrition during these times of special needs. WIC provides supplemental food, nutrition education, and encourages regular medical care for women, infants, and children who meet established income guidelines, live in a WIC service area, and have an identified nutritional need. Eligibility for the program is determined by a physician, nurse, or nutritionist.

The SMS Committee on Maternal and Child Health encourages physicians to work with the Wisconsin WIC program. Physicians can make referrals to the program by sending potentially eligible patients to the WIC agency in their area and by supplying appropriate medical data when available.

WIC Medical Referral Forms are available from a local WIC Project (see adjacent listing). The Wisconsin WIC Program is currently available in all Wisconsin counties except Calumet, Clark, Dodge, Sauk, Washington, and Wood. For further information contact: WIC Program, PO Box 309, Madison, WI 53701; phone (608) 266-5482. ■

Wisconsin WIC Service Area

County	Project
Adams—	Adams PHNS (608) 339-6325
Ashland—	Northwest CSA (715) 682-6661
Barron—	Barron Co. PHNS (715) 537-9202
Bayfield—	Northwest CSA (715) 682-6661
Brown—	Green Bay Area Free Clinic (414) 437-9773
Buffalo—	Buffalo/Trempealeau PHNS (715) 538-2311 Ext. 233
Burnett—	Burnett PHNS (715) 866-4277
Chippewa—	Chippewa Co. PHNS (715) 723-0391
Columbia—	Columbia Co. PHNS (608) 742-8558
Crawford—	Southwest CAP (608) 935-2811
Dane—	Dane Co. CAC (608) 266-6190
Door—	Door PHNS (414) 743-5511
Douglas—	Northwest CSA (715) 682-6661
Dunn—	Pepin/Dunn PHNS (715) 672-5961
Eau Claire—	Eau Claire Cty/Co. Hlth. Dept. (715) 839-5051
Florence—	Florence PHNS (715) 528-4837
Fond du Lac—	Fond du Lac Co PHNS (414) 923-1561
Forest—	Forest PHNS (715) 478-2214
Grant/— Green	Southwest CAP (608) 935-2811
Green Lake—	La Clinica (414) 622-4206
Iowa—	Southwest CAP (608) 935-2811
Iron—	Northwest CSA (715) 682-6661
Jackson—	Jackson PHNS (715) 284-4301
Jefferson—	Jefferson Co. PHNS (414) 674-2500
Juneau—	Tri-County PHNS (608) 269-8334
Kenosha—	Racine/Kenosha CAA (414) 657-0840
Kewaunee—	Door PHNS (414) 743-5511
La Crosse—	La Crosse PHNS (608) 782-5493
Lafayette—	Southwest CAP (608) 935-2811
Langlade—	627-4133
Lincoln—	Family Planning (715) 536-3311
Manitowoc—	Manitowoc City (414) 684-3331
Marathon—	Family Planning (715) 842-5633
Marinette—	Marinette PHNS (715) 735-3371
Marquette—	Marquette PHNS (414) 297-2624
Menominee—	Menominee PHNS (715) 799-3811
Native Americans—	Oneida Tribe (414) 869-2711
	All other Nat. Am. Great Lakes Inter-Tribal Counc. (715) 682-5202
Milwaukee County—	
	City of West Allis Health Dept. (414) 476-3770
	Family Hospital Teen Pregnancy (414) 344-9400
	Mil. Indian Health Bd.-Nat. Am. (414) 931-8111
	Guadalupe Clinic, Zip Code 53204 & Mil. Hispanic pop. (414) 643-9031
	16th St. CHC Zip Code 53204 (414) 672-7554
	All Other Co. Residents — CRSDC
	Northwest Side (414) 873-3982
	Northside (414) 263-3300
	Southside (414) 643-8444
Monroe—	Tri-County PHNS (608) 269-8334
Oconto—	Community Mem. Hosp. (414) 834-5151
Oneida—	Oneida Co. PHNS (715) 369-1484
Outagamie—	Outagamie Co. PHNS (414) 735-5109
Ozaukee—	Family Planning (414) 375-2402
Pepin—	Pepin/Dunn PHNS (715) 672-5961
Pierce—	Pierce/Polk/St. Croix PHNS (715) 273-4001
Polk—	Pierce/Polk/St. Croix PHNS (715) 485-3161
Portage—	Portage Co. PHNS (715) 346-2163
Price—	Price Co. PHNS (715) 339-3054
Racine—	Racine Health & Nutr. Srvc. (414) 637-7750
Richland—	Southwest CAP (608) 935-2811
Rock—	Wis. Health Care Review (608) 273-2216
Rusk—	Indianhead CAA (715) 532-6648
St. Croix—	St. Croix/Polk/Pierce PH (715) 796-2225
Sawyer—	Indianhead CAA (715) 532-6648
Shawano—	Shawano PHNS (715) 524-2169
Sheboygan—	Sheboygan City Hlth Dept. (414) 459-3417
	Sheboygan Co. Nurses' Office (414) 459-3030
Taylor—	Taylor PHNS (715) 748-3131
Trempealeau-	Buffalo/Trempealeau PHNS (715) 538-2311 ext 233
Vernon—	Tri-Co. PHNS (608) 269-8334
Vilas—	Eagle River Mem. Hosp. (715) 479-7411
Walworth—	Racine Family Planning (414) 723-5611
Washburn—	Washburn PHNS (715) 468-7419
Waukesha—	Waukesha PHNS (414) 544-8555
Waupaca—	Waupaca PHNS (414) 867-3126
Waushara—	La Clinica (414) 622-4206
Winnebago—	Winnebago Co. PHNS (414) 235-5100

The hassle factor

NOT LONG AGO a professor of international business at Indiana University developed a rating index for persons contemplating a career change. Professor Richard Farmer has suggested that persons in such a situation look beyond the more obvious financial considerations and examine such things as neighbors, educational facilities, pollution, healthcare, and some eight other concerns.

Under Farmer's system, the ranking of the elements results in what he calls the "hassle factor index"—an index that may reveal that a career change and relocation may not be what it seems to be on the surface.

The spirit behind Professor Farmer's index can be applied to much more than personal career choices. I would offer its application to that most unique creature in state government—the health planning system. Since 1977, the physicians of Wisconsin have been faced with one of the most comprehensive health planning laws in the nation. In March of that year the Legislature enacted a certificate-of-need, hospital "decertification" statute considered a model for other state governments.

After four long years, the "hassle factor" on health planning in general and on "decertification" in particular is so high that now only one reasonable solution remains for the State Legislature—repeal of the 1977 law. As someone who personally participated in the negotiations over the 1977 "compromise" law I nevertheless hold no claim over pride of authorship. Many physicians, it seems, were willing to attempt to work with a mandatory health planning system.

But now, after those four years, it is clear that this great experiment will *not* work and it deserves a quiet but quick death. Why?

After four years of meetings, conferences, negotiations, and debates, and after hundreds of physician hours on "technical advisory committees," and after who knows how many thousands of taxpayer dollars have been spent on planners, the fact is that the much heralded "decertification" of hospital services (physician services) cannot work.

And it will not work because the planners in the Wisconsin Department of Health and Social Services (DHSS) and the Health Systems Agencies (HSAs) in the state don't work. Do not misunderstand that charge, for the planners do put in their fair share of hard work and long hours. (Even I was a state employee once!) But the premise upon which the planners approach healthcare is at fault.

Consider: the "standards" used by health planners are often extracted from some dubious documents prepared in Washington, or as we call it around the State Medical Society offices, the "Land of Oz." These standards, which appear in state and regional health plans, are "number" standards seemingly pulled from thin air. Who is to say that "x" CT scans per year are necessary for an efficient cost-benefit ratio? As one Dane County legislator found out last year, local citizens have little use for Madison-developed "standards" if it means the scaling down or closure of a small local hospital.

Consider: the planning system suffers from a conflict of "shuns" (tions). Solu*tions* are offered through regula*tions.* The planning mentality is such that only regulatory actions will offer solutions to the benefit of the citizenry.

Consider: it has taken the DHSS Bureau of Needs four years to develop *proposed* administrative rules to deal with decertification; rules that in no way address the concerns of the medical profession, hospitals, or I dare to offer, the rights/responsibilities of local HSA staff and citizen planners. These standards do little but reflect the needs of the Madison-based planners.

At a recent meeting of the Wisconsin Clinic Managers Association, one of the legislators (an economist by training) that was a party to the 1977 compromise suggested that perhaps "CON" and "decertification" need to be reexamined. He also hinted that the former Administrator of Health (an economist by training), that also was a party to the 1977 law, had reached the same conclusion.

In 1980 the SMS House of Delegates reached a similar conclusion when it enacted a resolution calling for the repeal of the "decertification" subchapter of the 1977 law if the rules to implement it were not acceptable. Those rules are not acceptable, or appropriate, and the State Medical Society's Physicians Alliance will have a repeal bill ready for introduction in the 1981 Legislature around April 1.

Professor Farmer's hassle factor index has reached a new high with the Wisconsin Health Planning System. A successful candidate for Congress in the state last year told the local physicians in his district that national health insurance was "an idea whose time has come and gone." The same is true for hospital decertification.

Let's hope the 1981-83 Legislature reaches the same conclusion.

Brian H Jensen, *Director*
Physicians Alliance Division
of the State Medical Society
of Wisconsin ■

The Agent Orange controversy—physician's dilemma

Edward P Horvath Jr, MD, MPH, Marshfield, Wisconsin

THE HERBICIDE Agent Orange was sprayed extensively in Viet Nam from 1962 to 1971 to deprive the Viet Cong of food and cover. A combination of equal parts of the phenoxy compounds 2, 4-Dichlorophenoxyacetic acid (2, 4-D) and 2, 4, 5-Trichlorophenoxyacetic acid (2, 4, 5-T), Agent Orange has become the subject of considerable controversy. This concern is not centered on 2, 4-D or 2, 4, 5-T themselves but on the substance TCDD (2, 3, 7, 8-Tetrachlorodibenzo-p-dioxin), known as dioxin. This trace contaminant is an inevitable byproduct of 2, 4, 5-T synthesis. 2, 4-D does not contain dioxin. Current US manufacturing specifications require 2, 4, 5-T to contain less than 0.1 parts per million (ppm) TCDD. Agent Orange used in Viet Nam contained up to 50 ppm TCDD.

Due in part to increasing media attention, a substantial number of Viet Nam veterans has begun seeking medical and/or legal consultation for disorders they believe are due to Agent Orange exposure. This has created yet another environmentally-related dilemma for the practicing physician who is unlikely to be familiar with the known or suspected effects of dioxin. Furthermore, most busy practitioners are probably not aware of ancillary resources available to assist them in the medical evaluation of these patients. This paper briefly reviews the toxicity of TCDD, recommends a rational diagnostic evaluation, and identifies agencies providing further assistance to the concerned veteran.

TCDD is mutagenic in two bacterial systems and has resulted in chromosomal aberrations in rat bone-marrow cells. An increase in developmental abnormalities in rats and mice born to mothers treated with 2, 4, 5-T during early pregnancy has been reported. However, a recent study where 200 male mice were exposed to Agent Orange failed to result in a loss of fertility or increase numbers of offspring with birth defects. Conducted by the National Toxicology Program of the National Institute of Environmental Health Sciences, this study is particularly significant in that it attempted to simulate Viet Nam-type Agent Orange exposure where males were predominantly involved. The carcinogenicity of TCDD has been conclusively demonstrated in both rats and mice under specific experimental conditions.

Data on the toxic effects of TCDD in humans can best be described as inadequate and controversial. Studies of the population exposed to TCDD after the industrial accident in Seveso, Italy in 1976 revealed the following abnormalities: decreased nerve conduction velocities, an increase number of chromosomal aberrations and mild hepatic enzyme elevations. However, the subsequent rate of serious birth deformities in the exposed area was comparable to the national average. It is obviously too early to determine if there will be an increased incidence of neoplastic disease.

An industrial accident in a plant in Nitro, West Virginia in 1949 exposed many workers to high levels of TCDD. A 30-year followup of those employees who developed chloracne revealed no apparent excess of total mortality or deaths from malignant neoplasm over the followup period of nearly 30 years.

In 1979 the Environmental Protection Agency (EPA) banned most uses of 2, 4, 5-T citing a high miscarriage rate following the spraying of this herbicide in forests around Alsea, Oregon. That there continues to be widely divergent opinions regarding this episode was underscored by a statement from a recent "Dispute Resolution Conference" sponsored by the American Farm Bureau in Arlington, Virginia. The group reached a concensus that "such serious deficiencies exist in the [Alsea] data such that no conclusions [about an abortifacient effect of TCDD] are possible . . ."

The Vietnamese have reported an increased incidence of liver cancer between 1974 and 1977 in areas of Viet Nam sprayed with Agent Orange. Birth defects, miscarriages, and chromosomal abnormalities in inhabitants of the sprayed areas have also been alleged. However, tissue analysis of some of these patients has failed to reveal TCDD residues. Vietnamese medical personnel further admit that these findings represent clinical observations rather than well-controlled epidemiologic surveys and that

Doctor Horvath is Section Chief of Occupational Medicine, The Marshfield Clinic, Marshfield, Wisconsin. Reprint requests to: Edward P Horvath Jr, MD, The Marshfield Clinic, 1000 N Oak Ave, Marshfield, Wis 54449 (phone: 715/387-5523). Copyright 1981 by the State Medical Society of Wisconsin.

they cannot be conclusively linked to Agent Orange exposure in a causal fashion. More reliable evidence of a possible carcinogenic effect of TCDD in humans was recently reported out of Sweden. A case-control study demonstrated a six-fold increase in "soft tissue sarcomas" in workers occupationally exposed to chlorophenoxy compounds. However, detailed information regarding the nature of these neoplasms was not provided and further investigation is clearly needed.

Chloracne is the most frequent clinical manifestation of TCDD exposure and the only one universally accepted as causally related. It appears approximately six weeks after the exposure. It may resolve over a period of weeks or may persist for several years.

Hepatotoxicity, with increases in transaminases, lactic dehydrogenase and alkaline phosphatase and a more chronic hepatic porphyria type-A, have been found in exposed populations. A variety of musculoskeletal and neuropsychiatric manifestations also have been attributed to TCDD including headache, depression, insomnia, memory loss, impaired libido, joint pain and stiffness, hypersomnolence and fatigue. The nonspecific or subjective nature of these complaints underscores the difficulty of attributing them to any specific etiology.

The incomplete and controversial data regarding human health effects of Agent Orange have been reported extensively by the news media with the superficiality and sensationalism too often characteristic of coverage given scientific topics. This has created the misconception in the minds of many that there exists a clearly definable syndrome of chronic Agent Orange or dioxin toxicity. Considerable patient anxiety, political adversary posturing, and a flood of law suits have been among the initial results of this premature conclusion.

The diagnostic dilemma these developments pose to the practicing physician is obvious. Most of the disorders associated with Agent Orange exposure such as headache, hepatitis, and nervousness are nonspecific and relatively common in the general population. Similarly, the rate for spontaneous abortions and miscarriages in the general population ranges from 15 to 25 percent. Many veterans have fathered babies with congenital anomalies, but thousands of birth defects would normally be expected from any population of 2.5 million men. With the possible exception of the soft-tissue sarcomas noted in the aforementioned Swedish study, none of the other alleged dioxin-induced neoplasms are truly unusual. Furthermore, almost one quarter of our population will eventually develop malignant disease of some kind.

How then does one properly manage the anxious Viet Nam veteran with nonspecific complaints or findings or whose wife has recently experienced a miscarriage or delivered a child with birth defects? Can one make a diagnosis of a disease (Chronic Dioxin Poisoning) which has not been fully characterized? Although present toxicologic data are incomplete and inconclusive, sufficient information is available to justify a thorough medical evaluation of all concerned Viet Nam veterans. As Dr Peter Orris of the Occupational Medicine Section at Cook County Hospital recently stated, "It is incumbent upon practicing physicians to have a sympathetic ear to the complaints of patients with exposure to . . . these agents (Agent Orange). The physician should attempt to document objectively the etiology of these often vague complaints, while indicating to the patient the current difficulties in ascribing a definite causal relationship."

If the physician and patient are so-inclined, the initial medical examination can be conducted at one of the three regional Veterans Hospitals specifically designated for this purpose. (See addresses and phone numbers at the end of this article.) It is present VA policy to provide a thorough medical evaluation for all veterans in its patient population who claim exposure to herbicides in the Viet Nam Conflict and to follow them over a period of years so that any long-term complications resulting from these chemicals can be detected and possibly treated. The evaluation consists of a detailed exposure history, physical examination, and appropriate laboratory studies. Data will be entered into a registry maintained in a VA central office and tissue specimens from any pathologic studies forwarded to the Armed Forces Institute of Pathology. This effort and other studies presently being conducted will hopefully provide answers to questions regarding long-term toxicity.

If the patient prefers to have his family physician perform the initial evaluation, the following are recommended:

1. A thorough medical history with emphasis on gastrointestinal, hepatic, neuropsychiatric, neoplastic and reproductive complaints.

2. An exposure history to include the dates, locations, nature and intensity of Agent Orange or other herbicide exposure in Viet Nam. A complete occupational history documenting exposure to other chemicals and pesticides should also be included.

3. Physical examination with special emphasis on the skin (chloracne), liver, and nervous system.

4. Laboratory studies to include chest x-ray films, liver function tests, complete blood count with differential, renal function studies and microscopic urinalysis. Adipose tissue analysis for dioxin or other chlorophenoxy compounds is generally not available, expensive, and presently cannot be correlated with pathophysiologic

manifestations. It is therefore not recommended as a routine test.

It should be reemphasized that the aforementioned evaluation is the *minimum* recommended examination; other tests and studies should be done as clinically indicated. The major objectives of any medical evaluation are to exclude treatable causes of the patient's complaints and to document objectively those findings which may later be proven to be dioxin-related.

If the patient or his physician prefers a more detailed evaluation outside of the VA hospital systems, referral can be made to a specialized medical center. For veterans in the Chicago-Milwaukee area, Peter Orris, MD, Section of Occupational Medicine of Cook County Hospital in Chicago, directs a specific examination protocol (telephone number 312/633-5310).

The State of Wisconsin is conducting an identification and information program for the estimated 50,000 Wisconsin Viet Nam veterans who have been exposed to the herbicide Agent Orange. An "Agent Orange Hotline" has been established to answer questions (toll free number 1-800/362-3020). Other states and national veteran groups have established similar programs. An informational brochure to answer additional questions that veterans may have can be obtained from Mr Don Laurin, Coordinator of the State Agent Orange Program at the Department of Health and Social Services, Division of Health, Bureau of Prevention, 1 West Wilson St, Madison, Wisconsin 53701.

Even if the veteran decides to have his initial medical evaluation conducted elsewhere, he should be encouraged to contact his County Veterans Service Officer or nearby veterans hospital so the fact of his Agent Orange exposure can be firmly established and his name entered into the central data registry. Along with other epidemiologic studies, this will add to the growing body of knowledge regarding the possible chronic toxicity of these compounds. It also will insure that the individual veteran will be more likely to receive any medical or compensatory benefits which may be determined at a later date.

Wood VA Hospital
500 W National
Wood, WI 53193
Ph 414/384-2000, ext 2186

William S Middleton Memorial Hospital
2500 Overlook Terrace
Madison, WI 53705
Ph 608/256-1901, ext 375 or 213

VA Medical Center
54th St & 48th Ave South
Minneapolis, MN 55417
Ph 612/725-6767, ext 6400

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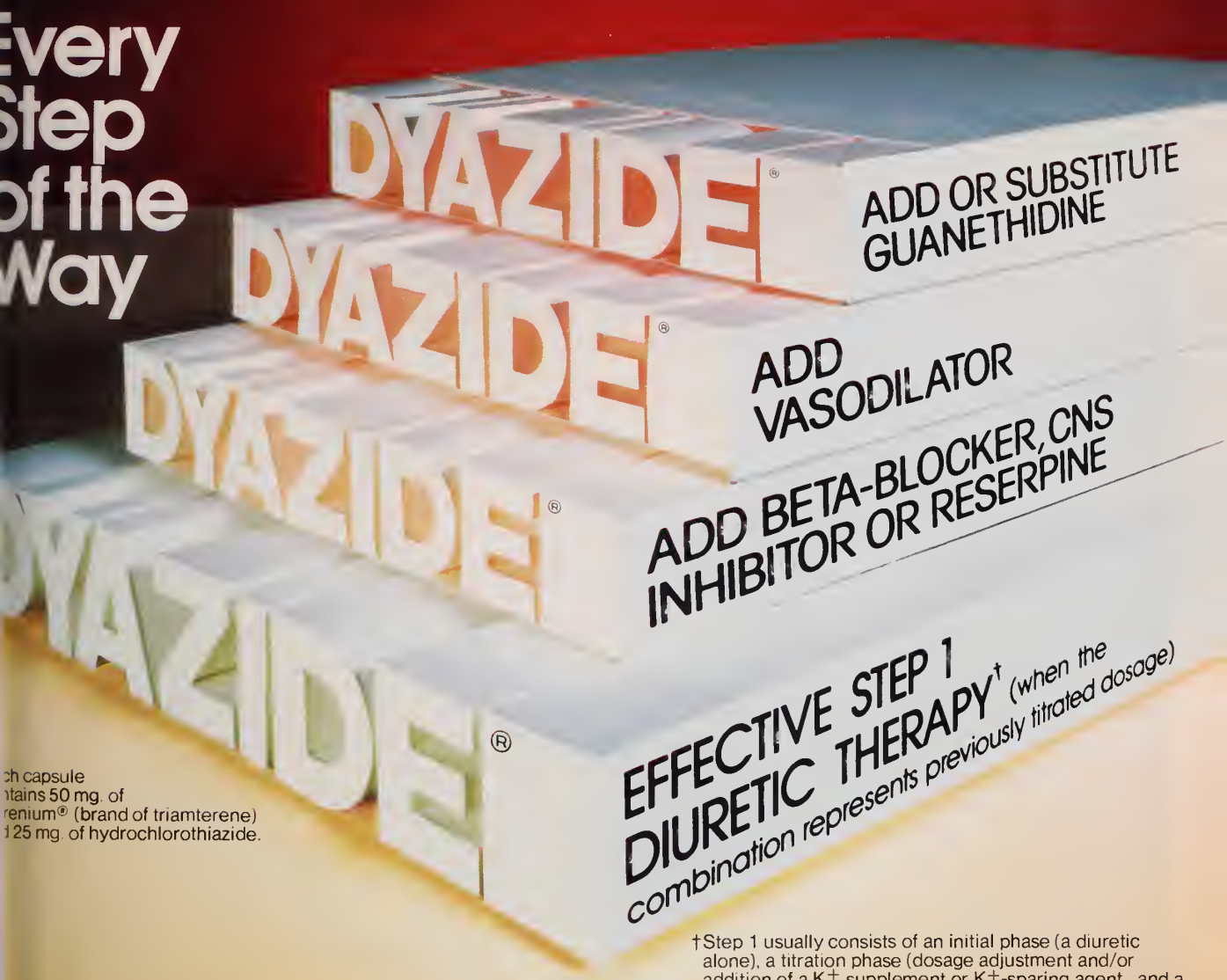
News You Can Use

By EARL THAYER, Secretary / BERNIE MARONEY, Assistant Secretary

HOTLINE ADVISES SENIOR CITIZENS ON HEALTH INSURANCE. Medicare-eligible individuals can receive health insurance counseling by calling a toll-free hotline: 1-800-362-3930. The ***Medigap Hotline,*** a project of the Center for Public Representation, provides information about currently marketed Medicare supplements, including coverage and cost comparisons. The Hotline staff also evaluates existing health insurance coverage and provides counseling services regarding replacement or cancellation of policies. Physicians may obtain posters and cards for their offices describing the Hotline's services by calling 1-800-362-3930; or writing: Medigap Hotline, Center for Public Representation, 520 University Avenue, Madison, Wisconsin 53703. The Hotline operates Monday through Friday from 10 AM to noon and from 2 PM to 4 PM. Counseling is provided free of charge.

AMBULATORY SURGERY SUBJECT OF DHSS STUDY. In accordance with a recommendation in the State Health Plan to increase the amount of ambulatory surgery in the state, the Dept of Health and Social Services (DHSS) has undertaken a study to categorize all surgical procedures according to the setting in which they are performed. Class one procedures would constitute those surgical procedures which could be performed in an outpatient setting such as a physician's office. Class two procedures are those which require some postsurgical monitoring and therefore should be performed in a free-standing surgical center or hospial day center. Class three procedures would require inpatient acute care. DHSS has asked the Wisconsin Chapter of the American College of Surgeons to assist in categorizing the surgical procedures. The Department has suggested that in the future, Class one procedures will only be reimbursed by the Medicare Program at the ambulatory care rate, regardless of where the procedure is actually performed. ■

n Hypertension*...When You Need to Conserve K^+



ch capsule
ntains 50 mg. of
renium® (brand of triamterene)
d 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

ore prescribing, see complete prescribing rmation in SK&F Co. literature or *PDR*. A brief mary follows:

VARNING
his drug is not indicated for initial therapy of dema or hypertension. Edema or hypertension equires therapy titrated to the individual If this ombination represents the dosage so determined, its use may be more convenient in patient nanagement Treatment of hypertension and dema is not static, but must be reevaluated as onditions in each patient warrant

ntraindications: Further use in anuria, progres- renal or hepatic dysfunction, hyperkalemia existing elevated serum potassium Hypersensi- to either component or other sulfonamide-ved drugs

nings: Do not use potassium supplements, ary or otherwise, unless hypokalemia develops etary intake of potassium is markedly impaired. upplementary potassium is needed, potassium ets should not be used Hyperkalemia can occur, has been associated with cardiac irregularities more likely in the severely ill, with urine volume than one liter/day, the elderly and diabetics with pected or confirmed renal insufficiency Period- y serum K^+ levels should be determined If erkalemia develops, substitute a thiazide alone, rict K^+ intake **Associated widened QRS com- or arrhythmia requires prompt additional rapy** Thiazides cross the placental barrier and ear in cord blood Use in pregnancy requires ghing anticipated benefits against possible ards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults Thiazides appear and triamterene may appear in breast milk If their use is essential, the patient should stop nursing Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids) Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency Watch for signs of impending coma in severe liver disease If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+ Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly Antihypertensive effect may be enhanced in post-sympathectomy patients Use cautiously in surgical patients The following may occur transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis 'Dyazide' interferes with fluorescent measurement of quinidine Hypokalemia, although uncommon, has been reported Corrective measures should be instituted cautiously and serum potassium levels determined Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium Chloride deficit may occur as well as dilutional hyponatremia Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

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The Clinical Laboratory Improvement Acts

A perspective of the process politic.

Part II of a two-part series.

George W Kindschi, MD, Monroe, Wisconsin

Since 1975, there has been a Clinical Laboratory Improvement Act in front of Congress each year. Each year it has failed to pass. This paper explores the reasons for failure and compares these more comprehensive bills to the existing law, CLIA '67.

NO SIGNIFICANT effort had been directed toward the clinical laboratory by the Federal government during the years between 1967 and 1975, but on May 14, 1975, Senators Jacob Javits and Edward Kennedy introduced S 1737, The Clinical Laboratory Improvement Act of 1975.

CLIA '75 was more sweeping in scope than was CLIA '67. The new bill provided for the licensure of all clinical laboratories by the Federal government in states where the laws and programs did not meet the standards set by the Secretary of HEW. Again, as in 1967, laboratories operated by physicians solely as an adjunct to treatment would be exempt. The bill would establish an advisory Council on Clinical Laboratories to provide consultation for the Secretary prior to the promulgation of rules and guidelines on quality assurance, record keeping, personnel, proficiency testing and accreditation inspections. In addition, an Office of Clinical Laboratories would be established in the Dept of Health, Education, and Welfare (DHEW) to centralize all functions relating to laboratory certification and registration. The hearings were held on September 8 and 9, 1975, Sen Edward Kennedy presiding.

In his opening remarks Senator Kennedy reviewed CLIA '67 and the progress that had been made. He stated that "clinical laboratory ineptitude" stories continued to appear on the nation's media. (A search of the lay literature at the time of this statement revealed only a few articles on the subject and they were directed basically against the growing fraud in the "Medicare Mills.") Senator Kennedy continued by saying that a General Administration Office study done in April 1975 showed that 32 of 44 diagnostic kits on the market were unsatisfactory. (Apparently he didn't understand that this was a manufacturing problem rather than a laboratory problem.) Neither the first draft of the bill nor the one finally passed by the Senate contained any reference to this manufacturing problem.

Senator Javits then followed Senator Kennedy and, although he claimed to be openminded, had a totally preconceived idea for the need for the bill and was not about to give much ground. He cited examples of what he claimed to be laboratory errors: an Iowa case of an incorrect bilirubin determination leading to brain damage in an infant; a California case of an "inadequate Pap smear" delaying the diagnosis of cancer; and an erroneous blood sugar test leading to a death in Illinois. If these examples were taken at face value, a case could be made that, indeed, the lab was at fault. But if they are carefully analyzed, it was as much inattention on the part of the attending physicians as laboratory error that lead to the tragic conclusions. This is not to hold the lab blameless, but to use these cases as prime examples of laboratory errors shows poor judgment in the choice of materials. Senator Javits concluded his remarks with: "This is a human problem which cries out for some kind of reform."

While the Johnson administration strongly supported CLIA '67, the Ford administration opposed CLIA '75. The executive branch thought that the bill was redundant and that ample controls existed through CLIA '67, Medicare and Medicaid rules, and through existing and proposed state laws. Dr Theodore Cooper, the Assistant Secretary of DHEW, testified on these points. He also noted that in 1975 there were 15,000 large labs in the United States and an additional 80,000 small office labs. He concluded that control of all of these labs was staggering in scope. At that point Senator Javits made it very clear that he wanted all 80,000 labs covered by this bill.

Some very surprising testimony came from a pathologist, Dr Paul Brown. His statements concerned the same Iowa case mentioned by Senator Javits: ". . . doctors at a small hospital in Iowa feared than an Rh baby had contracted Rh disease." He went on to say that the baby was sent to a larger hospital where the bilirubin value was normal. By the time the baby was returned to the small hospital, brain damage had occurred. Doctor Brown concluded, "He is now paralyzed and suffers from

Part I appeared in the February issue. Reprint requests to: George W Kindschi, MD, 1515 Tenth St, Monroe, Wis 53566 (phone: 608/328-7000). Copyright 1981 by the State Medical Society of Wisconsin.

mental retardation." This emotional testimony likely carried an inordinate amount of weight with the subcommittee since it corroborated their own feelings. This case did indeed show that there was a tragic laboratory error at the larger hospital; but for the bilirubin to be at a dangerous level, the baby would have to have been visibly jaundiced and the physicians at the larger hospital should not have accepted a normal value; they should have challenged it. No single laboratory test with either normal or abnormal results should be considered to be diagnostic of the presence or absence of disease. Therefore, the fault lay with the attending physician at the larger hospital as well as with the laboratory. In addition, Doctor Brown's phrase: "contracted Rh disease" is also incorrect since most physicians know that hyperbilirubinemia secondary to Rh incompatability is not a contagious disease. Doctor Brown cited other cases all with a bias against the laboratory. He created an atmosphere of the existence of widespread laboratory negligence. He strongly advocated that all laboratories be licensed as if it would be the cure-all of the problems he so vividly described.

Other testimony came from Dr Morris Schaeffer who had testified in 1966 for CLIA '67. He again cited his 1965 and 1966 studies and conceded that progress had been made, especially in New York. He and Senator Javits then engaged in a back slapping exchange on how great the New York system of licensing and regulating was. He then submitted exactly the same articles into the hearing record for CLIA '75 as he had submitted for CLIA '67. Apparently no new data had been generated.

The final committee report, authored by Senator Kennedy, indicated that the committee believed that all clinical labs were engaged in defacto interstate commerce and therefore could be regulated by the Federal government. (No testimony confirming or denying this assumption could be found in the hearing record.) The bill would defer authority to states which met or exceeded the standards set by the Secretary. It would end conflicting rules and regulations and impose nationwide standards. A two-year waiver would be granted to remote and rural hospitals which might have difficulty in meeting these standards. A blanket waiver was offered to any physician's lab filing a sworn affidavit attesting to compliance with the proficiency testing and personnel standards prescribed by the bill.

The committee voted 15 to 0 to send it to the Senate floor where, on Apr 29, 1976, after only a brief debate, it was passed 64-11 and sent to the House for consideration. It was the year's delay that changed the name to CLIA '76.

In December 1975 Rep Paul Rogers had introduced HR 11341 on the floor of the House and this bill was nearly identical to S 1737. The hearings were held in March 1976. The first to testify was Senator Javits. He cited the cases of "laboratory errors" that he had mentioned in his opening remarks to the Senate subcommittee. He urged rapid passage by the House. Much of the testimony that followed was essentially the same as the material presented to the Senate. Most witnesses testified for the bill but many had grave reservations about the broadness of its scope. The American Academy of Family Physicians wanted all small labs exempted while others testified that it was these small labs that were most error-prone. No hard data were provided for either case.

The most striking testimony came from the President of the American Clinical Laboratory Association, Doctor Pribor, when he described the laboratory inspection by the Joint Commission on the Accreditation of Hospitals:

> "DR PRIBOR: I have run through a number of JCAH inspections. The longest inspection lasted about 1½ minutes. There is no question - -
> MR MAGUIRE: How do you do an inspection in 1½ minutes?
> DR PRIBOR: You do not; you walk through the lab and leave."

It should be noted that the JCAH was not represented at these hearings. The remainder of the testimony added little to that heard by the Senate.

The bill never reached the floor of the House and, much to Senator Javits' irritation, died when Congress adjourned late in 1976.

Undaunted, early in the next session of Congress, he introduced CLIA '77. It was essentially the same bill that had passed the Senate the year before. Hearings were scheduled and the Senator's determination was reflected in his opening remarks at the hearings with statements like:

> "Larceny in the laboratory must be stopped."
> "This is a problem which cries out for reform."

He cited a 1976 HEW report:

> "Approximately 74 percent of the laboratories (surveyed) were found to have significant deficiencies . . ."

but did not say what they were or how many labs were surveyed or if they were the same Federal labs checked for CLIA '67. He also cited problems in the laboratories that were already certified. But the real insight into his renewed enthusiasm is found in the following quote:

> "It might interest the chair to know that I lost a close friend in this last year, a very close friend, because the blood type by error by mixing up one person's records with another for transfusions was incorrect and the patient died." (sic)

In the testimony that followed, his commitment to this bill was very evident. For example during testimony against exempting the small office lab, he said:

> ". . . Connecticut and California, both reply that there is a very material drop in performance in so-called office laboratories. This is the laboratories of the physician. Now there are the facts." (sic)

Many witnesses offered testimony which was nearly the same as the year before. No new facts were uncovered. The bill was reported out of committee and passed by the Senate by acclamation and then sent to the House.

In June 1977 hearings were heard by the Health subcommittee on the House version of CLIA '77, HR 6221. The testimony paralleled that heard in the Senate but little enthusiasm was ignited. The bill languished in the subcommittee.

In an attempt to gain some popular support for CLIA '77, Senator Javits wrote several articles for the medical and lay press. One of these appeared in the September 1977 issue of *The Internist*. He cited the statistics that showed that 7-26% of lab tests were in error adding:

> "The survey (of 200 Medicare laboratories) showed that 74 percent were found to have significant deficiencies—deficiencies which, when translated into human suffering, had severe consequences."

An inquiry by the author as to the validity of these facts brought this personal reply:

> "A study conducted by the Center for Disease revealed that unsatisfactory performance was demonstrated by 10-14% of laboratories in bacteriologic testing; by 35-50% in various simple clinical chemistry tests; by 12-18% in blood grouping and typing; by 20-30% in hemoglobin measurements; by 40-80% in differential characterization of blood cells; and by 20-30% in measurement of serum electrolytes."

These data are nearly identical to the data presented in testimony for CLIA '67 and were now being used to argue that there was still a problem!

Many articles now appeared in the professional journals which had been silent until this point. Studies were published refuting the figures presented in testimony. Yet, the general tone of these articles was that a Clinical Laboratory Improvement Act was on the way. Most of the authors believed that the only thing it would add to the laboratory was additional cost.

CLIA '77 did not reach the floor of the House and CLIA '78 followed exactly the same course. CLIA '79-80 didn't get as far as its predecessors. The question is, what happened?

Conclusions. The success or failure of a bill presented to Congress rests on many variables. The success of CLIA '67 was due to the fact that these variables were in a favorable mode.

First of all, in 1967 there was widespread support for the legislation. It was favored by Congress, the administration, laboratory professionals at all levels, and by the general public. The testimony presented at the hearings was aimed at modification of the bill into a workable, practical law.

Secondly, the bill was incremental in nature rather than proposing sweeping reform. Regulation was aimed at those who could be regulated. It presented logical, common sense requirements of quality assurance, proficiency testing, and personnel standards.

Thirdly, the bill encouraged both state government and private participation in its implementation. Lastly, the estimated cost was quite low realizing a positive cost-benefit ratio.

It is no wonder that not only did the bill pass by wide margins in both houses but also that it was widely accepted both by the public and by professional circles. It was believed by most to be a good law.

In the intervening years the amount of direct government regulation increased both inside and outside of the healthcare areas. The Occupational Safety and Health Administration (OSHA) was the most visible of these new regulatory agencies. As government regulation affected more and more people, the public in general began to shy away from regulation as a panacea for its problems. When the sweeping CLIA '75 was introduced, it not only had little public support, but even Congress was ambivalent to the need for such legislation. This was especially true among the members of the House.

CLIA '75 was opposed by the Ford administration on the grounds that it was redundant and covered areas of regulation already covered by existing law. Much of the testimony supported this contention. The stricter guidelines on personnel and proficiency testing were challenged as being unnecessary. In short, it was the opinion of many that the bill really wasn't needed. This opinion has carried over to the subsequent CLIA bills.

The article written by Rep James M Collins asking who would pay the 71 million dollars for CLIA '78 accurately reflected the mood of the House. Even the determination of Senators Javits and Kennedy to get the stronger CLIA passed could not move the House to act.

The analysis of the saga of the Clinical Laboratory Improvement Acts is a classic example of the "Issue Attention Cycle." With each new CLIA presented, the attention it received from the public, the health professionals, and Congress decreased. There was no outcry for reform; there is no great moral issue; but there was a significant cost for very little benefit.

The Clinical Laboratory Improvement Act is not dead, but it is in a state of suspended animation. It will stay there only if pathologists and technologists redouble their efforts to produce a quality product at an affordable price. Then, and only then, will the great CLIA dragon continue to sleep peacefully. Once again, the threat of regulation may work as well as or even better than regulation itself.

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continued ►

CME credits and medical licensure

Howard L Correll, MD, Arena, Wisconsin

CONTINUING MEDICAL education as a requirement for medical licensure is part of the large problem of medical care as influenced by legislative fiat which Dr Derward Lepley and I described recently.

Historically, over several thousand years, both the initial and the continuing education of the physician have to varying degrees been his personal, moral, and ethical responsibility.

During certain periods this responsibility was highly regulated by government, as is now the case. At other times it was left primarily to peer groups, usually made up of organizations of medicine. During these latter periods, the profession was expected to, and did, evolve codes of behavior more strict than the legal proscriptions of the time.

These were enlightened periods in the evolution of man and government, during which medicine could advance, and could police itself relatively well. This control was dependent on a strong voluntary ethical code, such as the Hippocratic Oath, and was supported by the careful selection of highly moral candidates by medicine's teachers. It was continued by constant peer supervision throughout the practicing life of the physician. These principles were backed up and supported, but never initiated, by government.

Presented before the Wisconsin Association of Senior Physicians convention, October 18, 1980, at the State Medical Society of Wisconsin, Madison, Wisconsin. Copyright 1981 by the State Medical Society of Wisconsin.

To the extent that these selective and supervisory principles could be supported by government, and could be voluntary and self-imposed by the medical community, medicine could advance. To the extent that these principles were imposed by law upon physicians and were bureaucratically regulated, they constrained both individual initiative and morality, stifled advancement, and denigrated the profession into a trade, more concerned with self-protection than with public service.

This was true in Babylon 4,000 years ago, where the repressive code of Hammurabi, specifying a "life for a life," adversely affected the quality and quantity of medical care—prescisely as the legal and legislative proscriptions of today threaten future medical care.

It has been forgotten again that he who cannot learn from history must repeat its mistakes. Morality has never been legislated. It must be taught by precept and example. As with all human endeavors, the moral boundaries are blurred, and the goals imperfectly achieved. But failure to achieve perfect behavior does not destroy a profession or a society, whereas failure of the majority to attempt ethical goals will destroy both.

The real purpose of government, with its legal apparatus, should be to actively support these attempts of the profession to attain the highest possible goal for the greatest public good. It should stand behind, and actively support, those peer

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mechanisms of organized medicine designed to protect the citizen from incompetence and deceit.

What government cannot do is legislate either ethical conduct or the specifics of medical education without, in the process, destroying medicine and eventually society itself.

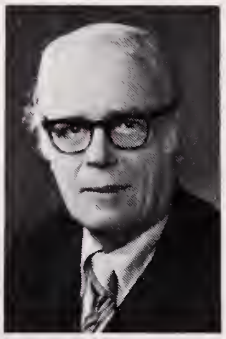
The current legislative interest in proscribing the hours of continuing medical education will fail in its alleged purpose of protecting the public through enhancing physician knowledge. It will not enhance the physician's medical knowledge or protect the public. What it will do, is further divide medicine into quarreling factions, and will worsen the moral climate inside and outside of medicine, through increasing suspicion and distrust of the motives of physicians. In the process it will force medicine to become a unionized trade for the protection of the physician from his government.

The majority of our lawmakers are inflicting these proscriptions upon society in a misguided spirit of public benevolence. They are apparently ignorant of the inherent despotism of their actions and of their destructive effects.

Continuing medical education, as a medical licensure requirement, is only one tip of the bureaucratic iceberg in the working sea lanes of society, but it is a visible warning of the danger to civilization in that bureaucratic nightmare. If not soon checked in its growth, may God have mercy on us all.

Thus, the main purpose of a retired (senior) professional organization should be to act as a moral and ethical beacon, warning of the danger, and by precept seeking reversal of the present trend. ■

DOCTOR CORRELL has served organized medicine in many capacities: president of the State Medical Society of Wisconsin, 1975-76; president of the Medical Society of Milwaukee County, 1969; chairman of the State Medical Society Council, 1976-77; member of the Board of Directors, Medical Society of Milwaukee County and Surgical Care-Blue Shield. He is now an honorary member of the Milwaukee and State medical societies and is retired, living near Arena. Doctor Correll is an emeritus clinical professor of medicine at the Medical College of Wisconsin and a fellow of the American College of Physicians and the American College of Cardiology. He also is a diplomate of the American Board of Internal Medicine. He is a fellow of the Council of Clinical Cardiologists of the American Heart Association and served as president of the Wisconsin Heart Association in 1954-55. Doctor Correll served as coordinator of the cardiovascular teaching and research at Marquette University School of Medicine (now MCW) from 1949-63.



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Probable carbon dioxide embolism during laparoscopy; case report

Steven L Nichols, BS; Bonnie M Tompkins, MD; and **Perry A Henderson, MD**
Madison, Wisconsin

LAPAROSCOPY IS AN indispensable surgical technique which allows the gynecologist or general surgeon to visualize endoscopically pelvic and abdominal anatomy without subjecting the patient to the stresses of laparotomy. However, it is not without its complications, and extreme care by experienced laparoscopists and anesthesiologists is essential if morbidity and mortality are to be kept at a minimum. Following is a report of a probable carbon dioxide (CO_2) embolism which occurred during insufflation for laparoscopy.

Case report. A 23-year-old white female presented for elective dilatation and suction curettage of an intrauterine pregnancy and sterilization via tubal banding. She was in good general health and had no previous complications with anesthesia. Preoperative medications included hydroxyzine 100 mg and atropine 0.4 mg. Following induction of anesthesia with sodium thiopental, intubation was facilitated with succinylcholine. Anesthesia was maintained with nitrous oxide, oxygen, and curare. Heart tones were monitored with a precordial stethoscope. Electrocardiogram, temperature, blood pressure, and inspired oxygen were also monitored.

During creation of the pneumoperitoneum, there was difficulty with placement of the Verres needle with free blood return at one point. Satisfactory pneumoperitoneum was eventually obtained. When insufflation was started, the surgeon noticed that the CO_2 flowmeter was bobbing with the patient's pulse. Simultaneously the patient's heart tones changed to a coarse sloshing sound and her heart rate increased from 80 to 110 beats per minute. Her face became dusky and the pulse and blood pressure were unobtainable. This course of events was suggestive of CO_2 embolism to the heart. Insufflation was immediately stopped and nitrous oxide was discontinued. The patient was placed in steep Trendelenberg position and hyperventilated with 100% oxygen. Had this measure not been successful, cardiopulmonary resuscitation would have been started immediately. At this point, however, the pulse, heart tones, and color returned to normal and the blood pressure was recorded at a systolic of 160 mmHg. Anesthesia was continued with fentanyl, oxygen, and curare. After several minutes nitrous oxide was resumed. There were no electrocardiographic changes throughout the incident.

Insufflation of carbon dioxide was started again at 1.0 liter per minute with an intraabdominal pressure of 15 to 20 mmHg. Laparoscopy revealed a normal 10-week size uterus with three puncture marks on the fundus. The fallopian tubes and ovaries appeared unremarkable as did the cul-de-sac. Twenty ml of unclotted blood was in the cul-de-sac, but no further free bleeding was seen. The stomach, liver, gallbladder, and diaphragmatic surfaces all appeared to be normal, as did the intestine and peritoneum. The laparoscopy with tubal banding was accomplished without further incident and the dilatation and suction curettage completed with laparoscopic visualization of the uterus during the procedure. The patient had a benign postoperative course and remained in the hospital overnight for observation.

EDITORIAL COMMENT: *An interesting case report detailing an acute surgical emergency. It combines a practical message with an appropriate and informative review of pertinent pathophysiology. In view of the fact that these procedures are being done in community hospitals, this is an appropriate article with valuable monitoring advice.*

Discussion. In addition to acute hypotension and cardiovascular collapse, other complications of laparoscopy include gastric regurgitation, visceral perforation, rupture of the diaphragm, mediastinal emphysema, pneumothorax, and pulmonary atelectasis.[1] Causes for hypotension or circulatory collapse have been attributed to cardiac arrhythmias resulting from inadequate ventilation in the presence

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of an artificially increased CO_2 level, reflex increase of vagal tone from excessive stretching of the peritoneum with subsequent bradycardia, compression of the inferior vena cava from increased intraabdominal pressure, gas embolism, hemorrhage from perforation of a major vessel,[2] and an acute reduction in peripheral resistance with CO_2 embolism.

Since carbon dioxide is insufflated at a rate of 1.0 liter per minute and the lethal dose has been reported to be 15-25 ml/kg in dogs or approximately 900-1500 cc for a 60-kg person, early recognition of gas embolism is mandatory if disaster is to be avoided.[3] It can be detected with close attention to clinical signs and with the aid of the electrocardiogram, a precordial Doppler ultrasonic flow detector, a central venous and/or pulmonary artery pressure monitor, and analysis of end-tidal CO_2. Clinical signs may be late in onset. A sudden onset of cyanosis, tachycardia, hypo- or hypertension, cardiac arrhythmias, and an alteration in heart tones may represent gas in the right ventricle and pulmonary artery. The development of a systolic murmur or a drum-like tone may precede the development of the classic millwheel murmur or continuous sloshing sound that is heard with a precordial or esophageal stethoscope.[4]

Diagnostic indices following experimental air embolism in dogs have been studied. Earliest changes, occurring with 0.5 ml/kg of air or less, included changes in Doppler sounds, an increased mean pulmonary artery pressure, and decreased end-tidal CO_2. Late changes, occurring with 2 ml/kg of air, were never consistently positive and included a decreased mean arterial blood pressure, increased mean pulmonary capillary wedge pressure, increased central venous pressure, the millwheel murmur, increased heart rate, cardiac arrhythmias, and electrocardiographic changes of right heart strain.[5] Further study has confirmed that the most sensitive detector of air embolism is the Doppler ultrasonic flow device but that the most sensitive indicator of hemodynamically significant gas emboli is the mean pulmonary artery pressure.[6] In that study a fall in end-tidal CO_2 occurred in approximately 70% of patients who had a rise in mean pulmonary artery pressure following air embolism. The Doppler ultrasonic flow detector, which is placed over the right parasternal area, will detect very small gas emboli (0.12-0.25 ml), many of which are hemodynamically insignificant.[7,8] In monitoring 100 patients for laparoscopy, however, no gas emboli were detected.[9] During laparoscopy the ultrasonic flow detector therefore may be a valuable early warning device if used on all patients since any CO_2 embolism could undoubtedly represent the beginning of a large intravascular insufflation.

With the continuous CO_2 infrared analyzer, a sudden fall in end-tidal CO_2 occurs when air, which has a low CO_2 content, enters the pulmonary artery. In CO_2 embolism, however, it is not known whether small amounts would result in a drop, no change, or a rise in end-tidal CO_2. The CO_2 analyzer therefore may not be useful as an early detector of gas embolism where CO_2 is the insufflating gas.

Definitive diagnosis of gas embolism is made with withdrawal of gas through a monitoring catheter placed in the right atrium or pulmonary artery. Although this maneuver has been found to be helpful in neurosurgery[10] others have been minimally successful at withdrawing embolized gas.[6,10,11]

The mechanisms of death relate to the size of the gas bubble, the solubility of the gas in the blood, and the hemodynamic consequences of the bubble in the heart and pulmonary circulation. Acute right ventricular dilation and failure, decreased left ventricular output with reduced coronary perfusion, hypotension, myocardial ischemia, arterial hypoxemia, and cerebral ischemia may occur. In addition, acute right ventricular hypertension may open the foramen ovale allowing for coronary artery embolism.[12] Systemic hypotension may occur in addition with CO_2 embolism because a sudden increase in arterial CO_2 may cause an acute reduction in the peripheral resistance.[13] This may account for the observation that hypotension appears more suddenly with CO_2 embolism than with air or oxygen.[3] Further, the lethal dose may be proportional to the weight of the subject and the size of the heart and the pulmonary artery. It has been postulated that the pulmonary insult is aggravated by the formation of platelet aggregates at the blood gas interface.[12]

Proper management of the patient at risk for gas embolization during surgery includes use of appropriate monitors and careful observation of the patient. In laparoscopy a gas that is rapidly absorbed by the blood should be used for insufflation. The lethal dose of embolized CO_2 is approximately five times greater than that of air. This is because CO_2 is more soluble in blood than is air and because the capacity for CO_2 carriage in the blood is markedly augmented by bicarbonate buffering and combination with hemoglobin and plasma proteins.[13]

Should embolization be detected, proper treatment is effected by immediately discontinuing insufflation of gas, hyperventilating with 100% carbon dioxide, and placing the patient in steep Trendelenberg position to float the gas bubble away from the right ventricular outflow tract into the apex of the heart.[14] If cardiovascular collapse occurs, cardiopulmonary resuscitation should be instituted immediately.[15] Placing the patient into the left lateral decubitus position (Durant's maneuver) may relieve tamponade of the right ventricular outflow tract and move the gas back out into the vena cava.[11,14,15,16] A central venous or Swan-Ganz catheter may be inserted through the internal jugular vein for aspiration of embolized gas. It is important to discontinue nitrous oxide (N_2O) as it will diffuse into an air pocket until it equilibrates. Since N_2O is 34 times more soluble than nitrogen (N_2) in blood, it will enlarge the size of an air bubble.[17] However, since the solubility of CO_2 in blood is similar to that of N_2O,

N_2O would only slow the decrease in size of the CO_2 bubble rather than cause an increase as with air. Other gases, however, such as oxygen (O_2) may diffuse into the bubble further slowing the resolution of the gas embolus.[18] Hyperventilation is therefore essential during CO_2 embolism as it will effect more rapid excretion of the exogenous CO_2 and N_2O.

Conclusion. Carbon dioxide (CO_2) embolism is a rare complication during laparoscopy. However, when it occurs, it can be lethal within minutes. For this reason it is recommended that every patient undergoing laparoscopy be monitored continuously with a precordial or esophageal stethoscope. Heart rate and blood pressure should be checked frequently especially during CO_2 insufflation, and the patient should be hyperventilated.[1] Doppler ultrasonic monitoring will give early warning of gas embolism and should be considered as a routine monitor during laparoscopy. Continuous analysis of end-tidal CO_2 as a diagnostic approach to CO_2 embolism during laparoscopy needs further investigation. The laparoscopist must remember the increased risk of uterine perforation in the pregnant patient. The anesthesiologist must always be prepared to initiate immediate therapeutic measures as soon as the diagnosis of CO_2 embolism is suspected. The patient in this case report was successfully managed because CO_2 was the insufflating gas and because gas embolism was suspected immediately, insufflation discontinued, and appropriate measures followed.

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Toxic shock syndrome bibliography developed

Waukesha Memorial Hospital Library Staff has developed a bibliography on the toxic shock syndrome. It is being shared with other state librarians. The list follows:

AM J DIS CHILD 134: 603-614 (June) 1980. *Acute febrile mucocutaneous lymph node syndrome.* Yanagihara R & Todd JK.

ARCH DERM 115: 1435-6 1979. *Possible Kawasaki disease in a 20-year-old woman.* Schlossberg D.

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SOUTH MED J, p 261, February 1980. *Rhabdomyolosis in a patient with nonoliguric renal failure: similarities to toxic shock syndrome.*

Ultrasound in the diagnosis of lymphangioma

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ABSTRACT. *This report describes a patient with a rapidly expanding retroperitoneal lymphangioma diagnosed by ultrasound. Conventional radiographic techniques provided little diagnostic information. Treatment is surgical removal or aspiration which can be sonographically directed.*

ULTRASOUND is rapidly being recognized in pediatrics as one of the primary imaging modalities in the evaluation of suspected abdominal masses. It is particularly advantageous in the infant and child because of the lower amount of body fat, and the close proximity of the skin to the abdominal organs. Differentiation between solid and cystic masses usually presents little technical difficulty. A lymphangioma has a characteristic appearance on ultrasound examination secondary to the multiple loculated fluid-filled cystic cavities which make up this distinct entity.

Case report. A nine-year-old black male presented with an abdominal mass. The patient's parents reported a protuberant abdomen since birth. Regular examinations by his pediatricians were considered within normal limits until approximately one year prior to this admission when increasing abdominal size was noted.

Physical examination was normal except for a large epigastric mass extending down to the right pelvis and lower quadrants. The mass was mobile, soft, ill-defined, and contained fluid by palpation. An upper gastrointestinal series revealed a large intra-abdominal mass (Fig 1). Transverse and longitudinal ultrasound images provided better definition of the mass (Figs 2, 3).

The sonography revealed a large, cystic, segmented mass with a striking reticulated pattern. The multiple cystic areas were echo-free indicating that these were multiple, separate, fluid-filled cavities with well-defined walls. A giant lymphangioma and hemangioma were considered as diagnostic possibilities.

At surgery a large, retroperitoneal, cystic structure was identified involving the lesser sac, transverse mesocolon, omentum, and anterior border of the pancreas.

The diagnosis of a giant lymphangioma was confirmed by pathologic examination. The specimen weighed 2,600 gm and measured 25 x 25 x 10 cm. The mass was reddish-brown and readily transilluminate. On sectioning the mass was found to be composed of innumerable, variably-sized cysts. The largest measured 10 cm in

Figure 1—Upper gastrointestinal series with small bowel examination. Note displacement of small bowel to the left and effacement of the ascending colon.

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diameter and the smallest 0.5 cm in diameter.

Microscopic sections revealed a conglomeration of irregularly-shaped spaces lined by flat endothelial cells. The cyst walls were composed of connective tissue, fat, smooth muscle fibers, and aggregates of lymphoid tissue. No atypical cells were identified.

Comment. The cystic lymphangioma has been considered the most important lesion of the lymphatics in childhood.[1] These benign lesions are of developmental rather than neoplastic origin, and the majority are evident in early childhood. Common sites include the neck, axilla, extremities, and face.[2,3]

Lymphangiomas may present as a mass at birth or in early childhood. The mass may grow slowly or rapidly with an apparent association between an infectious process and sudden enlargement. This is presumably secondary to the increased lymphatic activity associated with infection and the disturbed drainage capacity of the lymphangioma. These lesions also have been noted to spontaneously decrease in size for variable periods. Treatment is primarily surgical, although aspiration and drainage may be successful in unilocular or small multiloculated masses.

EDITORIAL COMMENT: *This is an interesting and instructive case report that illustrates the ever-expanding uses of sonography—in this instance, in pediatric diagnosis.*

The retroperitoneal location described in this case report appears to be unusual. Shivdev, et al,[3] reported 32 cases of lymphangioma with 30 cases histologically proven. Only one of these cases was in a retroperitoneal location. Masakuni, et al,[2] reported 177 cases with histologic proof in 164. Eight of these masses were located in the region of the "trunk" anatomically. Differential diag-

Figure 2—Longitudinal abdominal ultrasound. Note gallbladder (gb) and liver (L) with multiloculated cystic mass inferiorly.

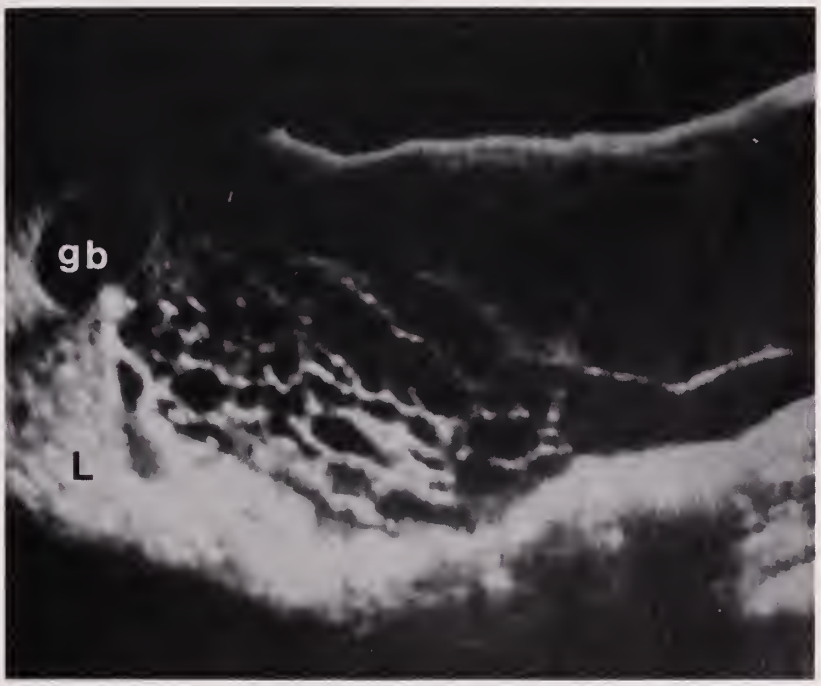

Figure 3—Transverse abdominal ultrasound. Note anterior abdominal wall (A) and posterior multicystic mass.

nosis depends partially on the anatomic location. Given the distinct sonographic appearance of the lesion, the differential is basically limited to a lymphangioma or hemangioma in the retroperitoneum.

Sonography has previously been demonstrated to be of particular value in the evaluation of cystic abdominal masses when compared to conventional radiography.[4] Ultrasonography should provide an excellent means of diagnosis, sonographic directed needle aspiration, and followup examinations in the management of lymphangiomas.

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Neutropenia in dysgammaglobulinemia I: Remission with immunoglobulin therapy

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ABSTRACT. *A three-year-old boy who presented with a severe perirectal infection was determined to have neutropenia in association with dysgammaglobulinema I (hyper IgM immunodeficiency). An increased concentration of IgM bearing lymphocytes was demonstrated in his peripheral blood. Intramuscular injection of immune serum globulin markedly increased his polymorphonuclear leukocyte (PMN) count and reduced his serum IgM level. Neutropenia associated with dysgammaglobulinemia type I is a rare but potentially treatable cause of neutropenia.*

DYSGAMMAGLOBULINEMIA type I (deficiency of IgG and IgA with increased or normal levels of IgM) has occasionally been associated with pronounced neutropenia.[1-6] The mechanism of this neutropenia is unknown. Immunoglobulin replacement therapy has been variably successful in increasing the polymorphonuclear leukocyte (PMN) count in such patients. We recently diagnosed the hyper IgM syndrome in a boy with a serious perirectal infection and neutropenia. His neutropenia has improved with periodic injections of immune serum globulin (ISG).

Case report. A three-year-old white male was admitted to the hospital with a perirectal infection and neutropenia. Five days prior to admission the child had been seen by a private physician because of persistent fever. A white blood cell count (WBC) showed 6300 μl with a differential count of 2 PMNs, 89 lymphocytes, and 9 eosinophils. He was treated with erythromycin. The day of admission the boy developed perirectal pain, and a perirectal abscess was noted. One year previously the patient had a cervical abscess which drained spontaneously. His parents also described a history of recurrent cutaneous furunculosis. There was no family history of recurrent infections.

On admission, the patient was noted to be less than the third percentile for both height and weight. Examination of the anus revealed an erythematous, tender, nonfluctuant 3-cm swelling adjacent to the anus that involved about one-third of the anal circumference. Necrotic appearing tissue was present centrally. Rectal examination revealed probable rectal crypt involvement. The patient's hemoglobin was 9.7 g/dl. His WBC count was 7200/μl with a differential count of 4 bands, 66 lymphocytes, 21 monocytes, 8 eosinophils, and 1 atypical lymphocyte.

The clinical impression upon admission was perirectal abscess and neutropenia of undetermined etiology. Broad spectrum intravenous antibiotic therapy was begun. Cultures of an aspirate of the lesion grew *Escherichia coli* and *Pseudomonas aeruginosa* but blood cultures were negative. The patient was given intravenous antibiotics for 19 days and received conservative local therapy (sitz baths and heat lamp) to the area.

Repeated WBC counts showed persistent neutropenia with a total absolute PMN count never rising above 300 PMNs/μl. A bone marrow aspirate revealed no sign of malignancy, but a maturation arrest was present in the myeloid series at the myelocyte stage and there was mild eosinophilia. Direct Coombs, rheumatoid factor, and antinuclear anti-

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Table 1—Response of neutropenia to ISG administration in dysgammaglobulinemia I

Date	WBC/μl	PMNs/μl	ISG	IgG	IgA	IgM (mg/dl)
5/15/78	3700	0		78	0	1000
5/21/78	7500	0	1.2 ml/kg	—	—	—
5/26/78	10000	100		—	—	—
6/8/78	18500	9250		—	—	—
6/19/78	13200	5150		130	0	606
7/5/78	14300	3300	0.6 ml/kg	42	0	261
8/17/78	13000	3500	0.6 ml/kg	48	0	342
8/23/78	11200	2100		129	0	244
2/22/79	7300	660	(0.6 ml/kg) (2/15/79)	69	0	234
3/29/79	6600	600	(0.6 ml/kg) (3/22/79)	88	0	248
5/5/80	4800	624	(0.6 ml/kg) (4/18/80)	62	0	405

ISG given every 4-5 weeks, only representative laboratory values reported here.

body assays were negative. Quantitative analysis of serum immunoglobulins revealed low levels of IgG, 78 mg/dl (normal: 701-1157), IgA 5 mg/dl (normal: 66-120), and IgD: 0.18 mg/dl (normal: 3-30 mg/dl). The IgM level was elevated at 1000 mg/dl (normal: 38-74). The diagnosis of dysgammaglobulinemia type I was made. On the seventeenth hospital day the patient received a loading dose of ISG (1.2 ml/kg) intramuscularly. Following administration of ISG, PMN counts rose and the IgM level fell (Table 1). A repeat bone marrow two months later was completely normal. Over the subsequent year the patient received ISG on a monthly basis. There was no recurrence of infection and PMNs have remained present in the peripheral circulation. It does appear, however, that the patient's PMN count is slowly dropping.

Studies of surface immunoglobulin markers were carried out using standard immunofluorescent antibody techniques on lymphocytes isolated from heparinized patient blood by Ficoll-Hypaque technique.[7,8] Nineteen percent of the patient's lymphocytes bore IgM, 8.5% IgD, 5% IgG, 1% IgE, and < 1% IgA. These levels were all within normal limits for patients of this age in our laboratory except for IgM-bearing lymphocytes which were elevated (normal range: 10-15%). The patient was determined to have a normal percentage of T lymphocytes (53%) by the sheep erythrocyte rosette assay.[7,8] Lymphocyte blastogenesis induced by either phytohemagglutinin, pokeweed mitogen or concanavilin A was within normal limits.[7,8]

Discussion. Dysgammaglobulinemia I (hyper IgM syndrome) was first described in two patients by Rosen in 1961. While not neutropenic, both these patients suffered from severe bacterial infections. Since then, several patients with this sex-linked abnormality of immunoglobulin production have been described. In addition to undue susceptibility to infection, a variety of associated hematologic abnormalities including neutropenia, thrombocytopenia, and aplastic and hemolytic anemia have been described.[9]

Neutropenia occurs in 10-15 percent of patients with hyper IgM syndrome. This combination of humoral and cellular defense deficits renders the patient extremely susceptible to invasive bacterial infection. Mucous membranes in particular are frequently infected in the neutropenic host. Two previously reported patients with hyper IgM syndrome associated with neutropenia developed perirectal abscesses and another developed severe ulcerations of the esophagus.[1,3,6]

EDITORIAL COMMENT: *This paper is a reminder to clinicians that dysgammaglobulinemia should be considered in cases of recurrent infection, with or without neutropenia.*

A number of patients with the hyper IgM syndrome and neutropenia have received periodic injections of ISG. Only three, in addition to the present patient, have had documented PMN responses to therapy.[2,3,5] Our patient's response to ISG appears to be decreasing. It has been suggested that these patients may develop antibody to exogenous immunoglobulin preparations, requiring more frequent and/or higher doses of ISG to maintain therapeutic effectiveness.[5] Of interest is the fact that during ISG therapy the serum IgM levels in our patient declined from exceedingly high initial levels as did the IgM levels in the patient treated by Rieger.[5]

Our patient was demonstrated to have an increased number of peripheral blood lymphocytes bearing IgM markers on their surface as recently

described by Geha et al.[10] The mechanism of the blockage of the production of immunoglobulins of other classes in this syndrome is unknown but has been suggested to be secondary to a lack of IgG suppression of IgM production.[10] The increase in serum IgG levels and decrease in serum IgM levels after administration of exogenous ISG in our patient could support this hypothesis.

Our patient has received monthly immunoglobulin injections for over one year. During this time he has not had any significant infections. Neutropenia associated with dysgammaglobulinemia type I is a rare, but medically treatable cause of significant neutropenia in the child.

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Abstracts

Presented at the Spring Meeting of the Wisconsin Neurological Society, May 9-10, 1980, Madison
Francis M Forster, MD, Madison, Program Chairman

The Medical College of Wisconsin experience with plasmapheresis in certain neurological diseases

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Susan M Koethe, PhD, Milwaukee, Wisconsin
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Disturbance in immune regulation has been implicated in the pathogenesis of myasthenia gravis, multiple sclerosis, and Guillain-Barre' syndrome. Recent advances in neuro-immunology have led to a better understanding of these diseases and have resulted in newer therapeutic approaches. Dau *et al* (*Neurology* 29:573, 1979) and Schauf *et al* (*Plasma Therapy* 1:33-42, 1979) have found modest improvement in chronic progressive MS patients after plasmapheresis (PP). Dau *et al* (*New Eng J Med* 297:1134-1140, 1977) demonstrated the efficacy of PP in MG patients resistant to conventional forms of therapy. Brettle *et al* (*Lancet* 2:1100, 1978) reported that PP was an effective treatment for acute idiopathic autoimmune polyneuropathy.

Removal of immunoglobulin by PP should have an effect on the immune system; the problem is to determine precisely what that effect may be, whether the effect correlates with any measurable clinical change and what all this may mean as regards PP as therapy for neurological disease.

To date we have treated five patients with chronic progressive multiple sclerosis, one patient with myasthenia gravis in crisis and two respirator dependent Guillain-Barre' patients with a series of PP therapies. Particular attention was paid to clinical changes relating in time to each PP. All patients have shown some clinical improvement of varying degree following PP. The improvement noted was step-ladder in character, coinciding with each PP. Serial studies of cellular immune function in particular have demonstrated changes which may define more clearly the immune basis of the illness to be treated and more precise the role of PP in treatment of such illness. ■

Complementary diagnostic procedures in occult breast carcinoma

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THERE IS GENERAL consensus that the best weapon we have against breast cancer is early detection and treatment. However, it is a fact that the majority of minimal (early) carcinomas are clinically undetectable. According to recent data from the Breast Cancer Detection Demonstration Projects (BCDDP), "investigators found that at the initial examination, mammography was able to detect 92 percent of the cancers, and 96 percent at the second screening (Beahrs et al, 1977).[1] Although there are a number of sophisticated diagnostic techniques available to augment clinical examination and mammography, there is some controversy among clinicians about the value of those techniques.[2]

Some physicians are of the opinion that if a "dominant mass" is present, aspiration and/or excision are the only viable alternatives. They believe mammography, breast ultrasound, galactography, pneumocystography, needle localization, and specimen radiography are superfluous or unnecessary.[3]

On the other hand, we believe that by utilizing these procedures in a complementary sequence when indicated, we are able to indicate whether biopsy is necessary, thus preventing needless surgery. Our experience with over 7,000 cases has demonstrated the need to evaluate each patient on an individual basis and to tailor the patient's examination and subsequent tests according to the correlated information obtained from the clinical history, physical examination, and mammography. We report a case illustrating this principle.

Case report. A 51-year-old woman was referred to the University of Wisconsin Hospital and Clinics for evaluation of a left breast mass which developed one month prior to admission. She had had two cysts aspirated in 1978.

The clinical impression was that of a freely mobile 4-cm lobulated mass lesion very likely benign in nature. Mammography was ordered for further evaluation. The examination defined two partially well-marginated densities in the left upper outer quadrant, but also disclosed adjacent subtle distortion of the Cooper's ligament suggesting desmoplastic reaction and suspicious microcalcifications. This appearance raised the possibility of a "minimal," clinically occult carcinoma, in addition to probably cystic lesions. Breast ultrasound was obtained and revealed the two contiguous nonechogenic, somewhat lobulated lesions with a strong back wall indicating the lesions were indeed cystic. Echographically, the adjacent suspicious area did not reveal a mass lesion.

The following day cyst aspiration was performed. Aspiration produced 3 cc of amber colored fluid from each cyst causing them to collapse. After aspiration the clinically detected mass disappeared, so a pneumocystogram was indicated for definitive tridimensional localization and evaluation of the adjacent subtle distortion of the connective tissue.

Figure 1—Black arrows indicate area of concern. Open arrows outline the patient's mass lesions.

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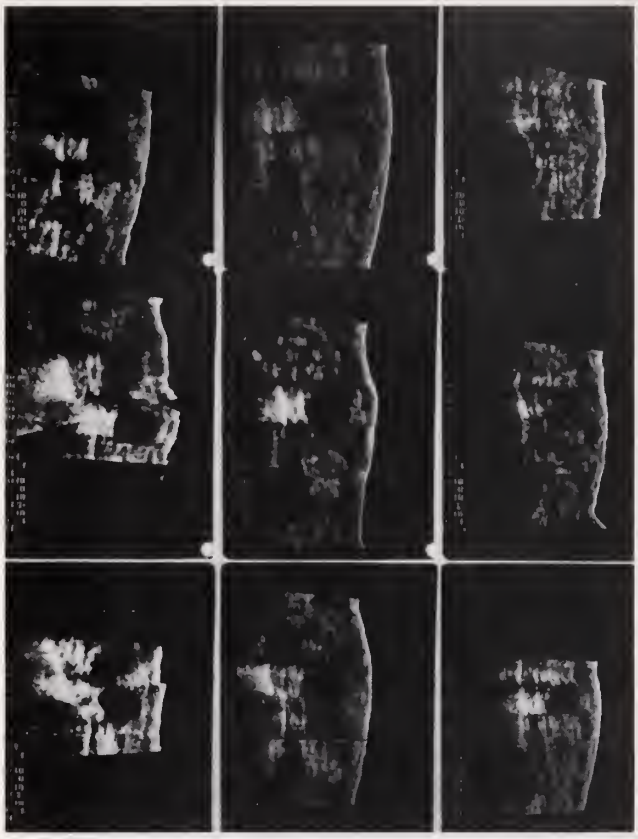

Figure 2—Ultrasound discloses classical cystic appearance.

Figure 3—Pneumocystogram demonstrates relationship of area of concern and the cystic lesions.

Figure 4—Specimen radiography. Open arrow indicates calcifications adjacent to the carcinoma.

Contrast examination demonstrated no intracystic growths, the suspicious area was exactly localized, preoperative needle localization was carried out under local anesthesia, and the lesion excised. Specimen radiography was requested for complete evaluation.

Fibrocystic disease was the surgical macroscopic impression of excised tissue. Subsequent specimen radiography showed malignant-like microcalcifications and a dense nodule of less than 1 cm. The permanent section was interpreted as infiltrating ductal carcinoma. Modified radical mastectomy was performed next. Axillary dissection revealed no metastatic nodes.

Conclusion. This case exemplifies the necessity for complete and thorough investigation of a breast mass. If only cyst aspiration had been obtained, this patient's clinically occult carcinoma would have gone undetected.

If we are going to see an increase in the cure rate of breast cancer, we must aggressively but discriminantly utilize all the diagnostic tools we have available.[4]

REFERENCES

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3. Hoehn JL, Williams GH, Hardacre JM, et al: Expanding role of mammography (Letters). *Wisconsin Med J* 78 (12): 8 (Dec) 1979.
4. Matallana RH: Expanding role of mammography. . .continued (Letters). *Wisconsin Med J* 79 (1): 11 (Jan) 1980. ■

Governor proposes $2.564 billion Medicaid budget

Wisconsin Governor Lee Dreyfus formally introduced his 1981-83 budget proposal January 27 to the Legislature. What follows is a brief summary of several key items regarding the Medicaid Program, as provided by the SMS Physicians Alliance.

The Governor is recommending a Medicaid budget of $795 million, $841 million, and $928 million for the years 1981, 1982, and 1983 respectively. The first of these figures, $795 million is a re-estimate of expenses for 1981 fiscal year which ends on July 1, 1981. This re-estimate is required because in all funds the program was over-expended by nearly $34 million. The latter two amounts are for the next two years commencing July 1, 1981. Even though the amounts are increases over the previous biennium, they represent a cut in what expenses would have been had the status quo been preserved in the 1981-83 budget period.

The Governor's budget for Medicaid assumes the following breakdown by provider:

Nursing Homes	60%
Hospitals	18%
Drugs/Supplies	6%
Dental/Other	9%
Physicians	7%

The budget is projected to be contained through a number of benefit and procedural changes including:

•Limiting of services to the "medically needy" (about 6% of the recipient population) to the federal mandatory services *plus* intermediate nursing home care and emergency transportation. Eliminated for the medically needy will be all other optional services, such as chiropractic, dentistry, podiatry, non-MD vision care, the therapies, etc. (NOTE: chiropractic care for all other recipients *is* a covered service—the Governor having changed at the last minute the recommendation of DHSS that chiropractic be eliminated for all recipients.)

•Because of the way the budget language is written, DHSS may *at its option* eliminate other optional benefits for all recipients, including the following when prescribed by a physician:

a. intermediate care facility services;
b. physical and occupational therapy;
c. speech, hearing, and language disorder therapies;
d. medical supplies, and
e. inpatient hospital, skilled nursing facility, and intermediate care facility for patients of any institution for mental diseases who are under 21 or over 65;
f. day treatment;
g. nursing services;
h. drugs; and
i. insulin and antacids.

In time of a financial shortfall, the Department could either prorate payments or eliminate or restrict optional services, including those above. This language therefore gives DHSS wide authority over benefits in the case of insufficient funds *without* obtaining further legislative *approval.* (*Notification* to the Legislature would be required.)

•The Governor is recommending that recipients be required to make co-payments of 50¢ for drugs, and $1 for dental and eyeglasses.

•Podiatry and over-the-counter drugs are eliminated for *all* recipients.

•Psychotherapy would be limited to only those services performed through 51.42 Board facilities or by providers with contracts with those boards. Therefore, "outpatient psychotherapy" in the office setting would not be a covered service.

•The budget also calls for a maximum increase in physician fees via the profiles of 4.5% in 81/82 and 4.5% in 82/83. This is well *below* the historical increases. Federal recommendations will not be available until later this spring.

The SMS Council January went on record as opposing this limit and will seek legislation which would prevent DHSS from reimbursing providers under Medicaid at a rate less than that set by the Federal government for the Medicare Program.

•Hospital and nursing home increases will also be limited, although in the neighborhood of 8-9% per year.

•The Governor is asking for statutory authority to place a freeze effective October 1, 1981 on all nursing home bed expansions for two years and all certificate-of-need applications from hospitals for two years when the hospital construction project exceeds $250,000.

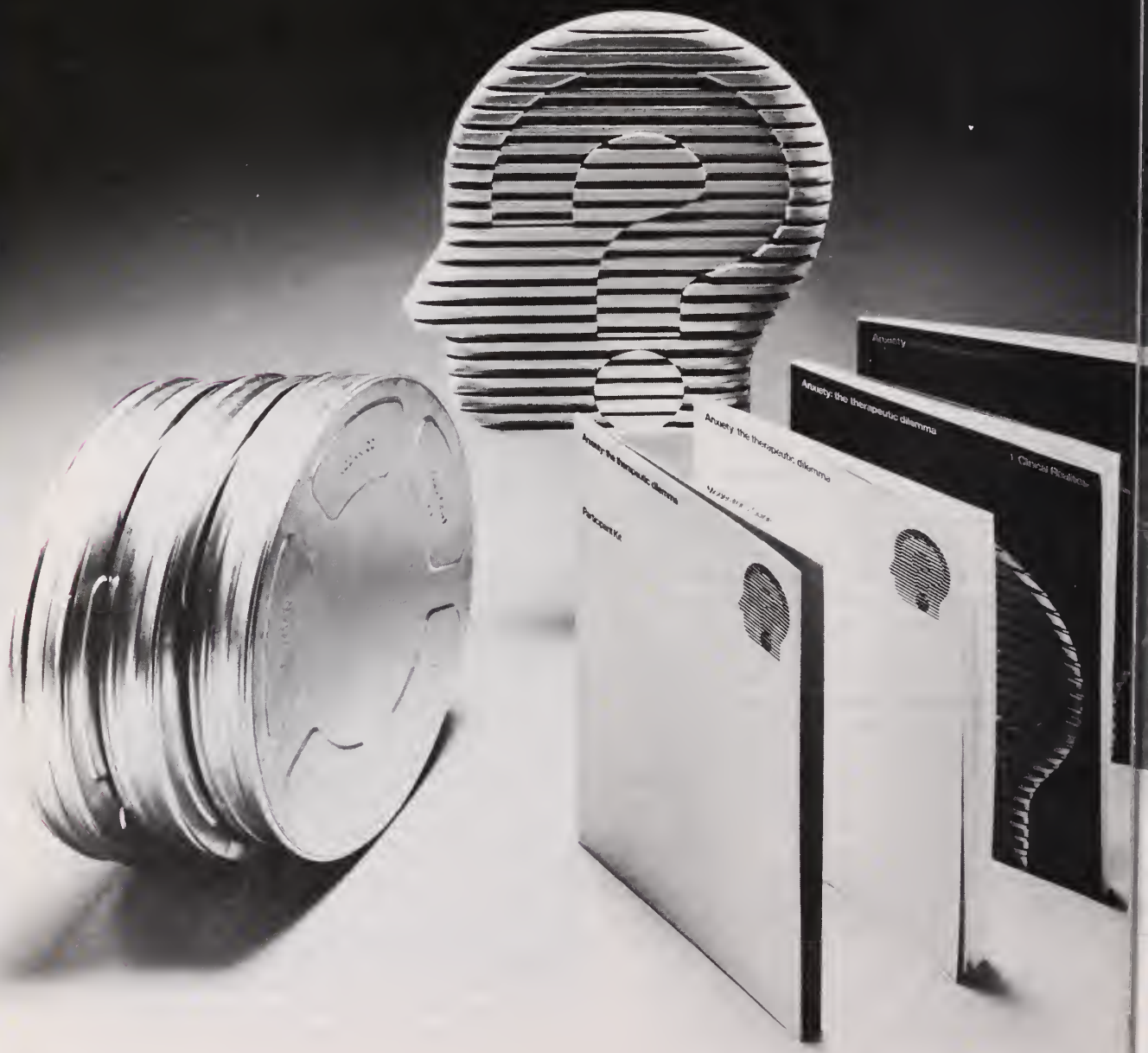
The SMS Council January 24 voted to oppose this provision.

•Under this bill, reimbursement for hospital and x-ray services may not exceed the payment made for "comparable services performed by providers not owned or operated by hospitals." ■

Now...today's issues in anxiety management are confronted in a unique program for primary care physicians

Anxiety: the therapeutic dilemma

Multimedia Continuing Education Program



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Institution _____

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Council to fight 4.5% maximum fee increase in Title 19

The Council of the State Medical Society, January 24, went on record as opposing a proposal in the 1981-83 Wisconsin State Budget, as proposed by Governor Dreyfus in January, which would set a limit on the maximum increase in physician reimbursement under the Medicaid program to 4.5% in 1981-82 and 4.5% in 1982-83. The Council will seek legislation to prevent DHSS from reimbursing providers under Medicaid at a rate less than that set by the Federal government for the Medicare Program.

The Council also voted to oppose a request of the Governor to obtain statutory authority to place a freeze effective October 1, 1981, on all nursing home bed expansions for two years and all certificate-of-need applications from hospitals for two years when the hospital construction project exceeds $250,000.

Other Council actions:

ENVIRONMENTAL HEALTH

. . .The Council supported a recommendation by the SMS Committee on Environmental and Occupational Health to oppose DHSS plans to eliminate sanitation inspections (camp sites, swimming pools, trailer camps, etc) by the State and transfer the duties to local or county health departments.

STATEMENT ON OXYTOCICS

. . .Referred a proposed revision of the SMS Statement on Oxytocics to the SMS Section on Obstetrics and Gynecology for further study.

QUALITY ASSURANCE

. . .The Council supported, in principle, a report by the Ad Hoc Committee on Quality Assurance which calls upon the Medical Examining Board to act as a clearinghouse for the accumulation and dispersal of information concerning disciplinary actions taken by hospitals against physicians whose privileges have been reduced or removed for practical cause. Staff was directed to draft a bill incorporating this system for perusal by SMS Commission on Governmental Affairs and the Council.

MEDICAL EXAMINING BOARD

. . .The Council opposed a proposal by the Dept of Regulation and Licensing which would transfer the administrative rule making functions of the Medical Examining Board to the Department. The proposal would limit the Board to serving in an advisory capacity to the Department, primarily in the disciplinary area. It would not allow the board to initiate, on its own, rules for the conduct of physicians in Wisconsin.

SMS BUDGET

. . .The Council approved a 1981 budget of $1,605,000 for the State Medical Society, which emphasizes membership recruitment and retention and the need to expand SMS Services, Inc benefit programs to members.

ANNUAL MEETING

. . .The Council will recommend to the House of Delegates that LaCrosse be the site of the 1985 Annual Meeting.

AUXILIARY

. . .SMS officers met with officers of the SMS Auxiliary to discuss goals and objectives of the Auxiliary for 1981. These include: targeting several counties for creation of local auxiliaries in 1981; sponsoring the 1981 Work Week of Health with an alcoholism theme; assist SMS in its membership recruitment efforts during 1981; and urging county medical societies to invite local auxiliary officers to attend their regular county society meetings.

SMS MEMBERSHIP

. . .The Council accepted a report from its Membership Committee which outlines several recommendations aimed at increasing physician membership in the State Medical Society during 1981.

PATIENT COMPENSATION PANELS

. . .The Council supported a bill to be introduced in the 1981 legislative session which would raise the threshold for claims before informal patient compensation panels from $10,000 to $25,000. The bill would also impose a $25,000 limit on recovery if a case, originally heard by an informal panel, is appealed to a circuit court. A bill dealing with patient compensation panel membership was sent back to the SMS Committee on Medical Liability for further consideration. Among its provisions, the bill would require referral to the Medical Examining Board of any physician who refused to serve on a patients compensation panel unless excused by the Director of State Court. In such case, the Board could, but need not, make a finding of "unprofessional conduct." The Council expressed a preference for the use of subpoena powers by the panel to secure the participation of such physicians.

NATIONAL ISSUES

. . .The Council endorsed a report by the Ad Hoc Committee on National Issues which makes several recommendations to emphasize discussion of national issues at SMS Council and commission meetings and county medical society meetings. The report also calls for appointment of a reference committee on national issues during the SMS Annual Meeting.

SMS REALTY

. . .Eugene J Nordby, MD, Madison, was reelected a Trustee of the SMS Realty Corporation. ■

Museum contribution

In December the State Medical Society of Wisconsin contributed $1,000 to the CES Foundation for the Museum of Medical Progress in Prairie du Chien. ■

SMS Governmental Affairs Commission reviews legislation

The budgets of the UW Medical School and the Medical College of Wisconsin, a proposal to ban the sale of drug paraphernalia, and the right of optometrists to use eyedrops were reviewed by the Society's Commission on Governmental Affairs (GAC) this month. In its review the Commission:

•Voted to support both Assembly Bill 55 authored by State Rep Dorff and AB 58 by Rep Klicka which would create statutory restrictions on the sale and manufacture of drug paraphernalia. The bills are both based upon model legislation drafted by the Drug Enforcement Administration of the US Department of Justice. Similar legislation died in the last session of the Legislature.

•Voted to express to the Legislature the Commission's opposition to proposed cuts in the budgets of both the University of Wisconsin and the Medical College of Wisconsin. The Governor has rejected a request from MCW that would add funds to the Family Practice program, although he did approve about $268,000 in 1981-82 and $271,000 in 82-83 for the addition of six half-time faculty positions. The situation at the Unviersity of Wisconsin is even more critical in that the school has lost some federal capitation grants and the Governor has rejected proposed increases in the operating budgets of the UW hospital/clinics. Dreyfus also suggested in the budget bill that the faculty practice plan make a greater "contribution" to the operating budget of the school, although the amount of that transfer is set by contract between the faculty and the medical school.

•Directed the SMS Physicians Alliance staff to prepare legislation to amend the 1979 law which revised the medical records access statute in the state. Under the 1979 law, patients are required to submit a statement to their healthcare provider if they do not wish their personal medical records to be made available to state investigators. The GAC position is that if state personnel wish access for audit or investigatory reasons, the state should be responsible for obtaining patient permission rather than requiring patients to act to prevent access. This amendment will be drafted for introduction later this session and an attempt may be made to add the GAC language to the budget bill.

•Received information that the Department of Regulation and Licensing wants to repeal the 1979 language that provides a 1982 "sunset" on the authority of optometrists to use eyedrops. Under the law, optometrists may use certain drugs specified by administrative rule but must report adverse reactions to the department and refer patients to a physician. Department data claims that nearly 100,000 people received eyedrops from optometrists since the passage of the law but only 20 "adverse" reactions have been reported. Representatives of the Section on Ophthalmology expressed concern over the possible repeal of the reporting mechanism and suggested that the reports be required and reviewed by physicians in the event the law is made permanent after 1982.

•Reviewed a report prepared by the Council's Ad Hoc Committee on Quality Assurance that calls for reporting the Medical Examining Board of changes in a physician's hospital privileges and related matters. The SMS Council has approved the Ad Hoc Committee's report and asked the GAC to prepare legislation to implement its recommendations.

Attending the Commission's meeting on behalf of the Medical College of Wisconsin were Thomas Garland, MD, acting chairman of the Department of Family Practice, Mr Donovan Riley of the administration, and Ms Anne Finnegan, administrator of the family practice unit. Representing the University of Wisconsin Medical School was Arnold Brown, MD, dean of the school. ■

Kudos given to SMS video show

The State Medical Society's videotape, *SMS: A Look From the Inside*, is now an award-winning production. The American Medical Association recently announced that the SMS program had won the "Gold Award" in Category V (Public Audience Speech) of the 1980 AMA National Awards Program for Medical Speakers. The videotape, which was produced by SMS staff member, Mike Brozek, was selected among numerous entries by a 12-member panel of judges composed of news media personnel, public address experts, and communications specialists. The award plaque was on display during the AMA's National Leadership Conference February 13-15. In addition to the plaque, SMS received a cash award of $1,000. The videotape is currently available for scheduling at county medical society, hospital medical staff, and other medical meetings. To schedule the program contact a Physicians Alliance field consultant or Mike Brozek at SMS Madison headquarters.

In a related matter . . .SMS was honored by the AMA during its February 13-15 Leadership Conference for exceeding its 1979 AMA Year-End Membership. SMS and AMA membership was up 83 members in 1980 over 1979. ■

Don Peterson returns to SMS

A familiar figure to Wisconsin physicians has returned to the State Medical Society staff. Donald F Peterson has joined the SMS staff as manager of its Service Programs. He replaces Peter Wood who resigned to accept the office manager position with a Milwaukee law firm. Don previously was an SMS employee for several years in the WPS Division. Recently he had been vice-president and executive director of the Greater Health Plan, a privately funded and operated IPA/HMO, sponsored by Wisconsin Employers Group, Green Bay. As manager of Service Programs, Don will be developing and promoting tangible benefits to SMS members. ■

Washington County Jail earns accreditation

The Washington County Jail received a certificate of accreditation from the State Medical Society of Wisconsin's Jail Health Care Program January 28 during the Winter Conference of the Wisconsin Sheriffs and Deputy Sheriffs Association at the Red Carpet Inn in Milwaukee.

The two-year accreditation was awarded to the facility "for providing acceptable medical care and health services which meet the standards developed by the American Medical Association (AMA)."

Warren Williamson, MD, Racine, chairman of the State Medical Society's Jail Health Care Technical Assistance Committee, presented the certificate of accreditation to Washington County Sheriff Clarence A Schwartz.

In order for a jail to become accredited under the program, it must comply with a sufficient number of the 69 standards for health services in jails. Required standards range from each jail having a physician directing the operation of the jail's health services to jail personnel taking a health history of each inmate when he or she is admitted to the jail.

Other procedures covered by the standards include sick calls held by medical personnel, nonemergency care, preventive medicine, and detoxification from alcohol and drugs.

In Washington County a sick call system has been instituted whereby a nurse makes regular visits to the jail to monitor and treat health problems of inmates. Those inmates requiring further treatment are referred to a physician.

Thomas E Wex, MD of the West Bend Clinic oversees the Jail Health Care Program in the Washington County Jail. Delores Harder, RN, Director of the Washington County Community Health Nursing Service and a member of the SMS Jail Health Care Technical Assistance Committee, supervises the county nurses who serve the jail. Alcoholism and mental health counselors from the local Comprehensive Community Services Agency also see inmates who need their services.

What is it about the jail health care program and its accreditation process that makes it so attractive to jail personnel? Washington County jail staff point to potential decrease of future lawsuits concerning inmate health care delivery, and the cost-effectiveness of the program as reasons for their participation.

Jail personnel feel the likelihood of an inmate successfully pursuing a medical suit in court is substantially decreased when an AMA-accredited health delivery system is a part of the jail's procedures.

Secondly, jail staff have found the program to be less expensive than the manner in which services were obtained previously. Prior to the Jail Health Care Project in Wisconsin, health care services in most of the state's jails were provided in hospital emergency rooms or doctors' offices. In many instances medical complaints of the inmates were not serious enough to warrant treatment at either of these locations, resulting in an unnecessary expense for the community.

Under the sick call system at the Washington County Jail, many of these routine problems are handled by the nurse. For example, from the time when the sick call system began in April 1980 through year-end 1980, 83 inmates were seen by the nurse; only 25 were referred to outside medical personnel.

Warren Williamson, MD (left) presents certificate of accreditation to Washington County Sheriff Clarence Schwartz.

The community also benefits from the program, since nursing assessments now done in the jails have cut down on the incidence of undetected and untreated communicable diseases, which would make their way into the community upon the inmates release.

The State Medical Society of Wisconsin was one of the first six medical societies in the country to participate in the Jail Health Care Program begun by the AMA in 1976. Twenty-three states presently participate in the jail program.

The Wisconsin Society is now working with 29 other county jails in developing health care programs. ■

Historical perspectives of Wisconsin Medicine subject of one-day program

Physicians will have an unusual opportunity to learn more about the history of their profession in Wisconsin at a special symposium being sponsored in part by the Aesculapian Society of the State Medical Society's Charitable, Educational and Scientific Foundation on May 9, 1981 in Marshfield.

"Wisconsin Medicine: Historical Perspectives" will cover a wide array of topics such as: "From Horse and Buggy to Auto and Phone; Medical Practice in Wisconsin, 1848-1930" by Guenther Risse, MD, PhD, UW-Madison; "Public Protection and Self-Interest: Medical Societies in Wisconsin" by Ronald L Numbers, PhD, UW-Madison; "From Infirmaries to Intensive Care: Hospitals in Wisconsin" by Mary Van Hulle Jones; "Health and Healing in Rural Wisconsin" by Dale E Treleven; "From Bad to Better: Health in Urban Wisconsin" by Judith Walzer Leavitt, PhD and "Sectarian Healers and Political Process" by Edmond R Minihan.

Cosponsoring the symposium with the Aesculapian Society are the Department of the History of Medicine, UW-Madison; and the Marshfield Medical History Club. For further registration detail contact program organizer, W Bruce Fye, MD, Marshfield Clinic, 715/387-5258. ■

SMS membership up, District 1 gains councilor

The SMS Membership Department recently announced that SMS-AMA-County society membership (paid) for 1980 totaled 4,748—an increase of 83 members over 1979. The rise in membership in District 1 (southeastern Wisconsin) means that in 1981 it will gain an additional council seat, bringing its total to 10 councilors. All other councilor districts remain unchanged.

In regard to delegates to the SMS House of Delegates, the following county medical societies will receive an additional delegate as a result of membership increases in their areas: Brown, Dane, Oneida-Vilas, and Outagamie. The total membership in the SMS House of Delegates, including specialty section representation is now 161. ■

SMS annuity unit value $3.99

The SMS variable annuity contract accumulation unit value, applicable to the SMS-sponsored retirement (Keogh) plan for self-employed physicians was $3.99 as of December 31, 1980. This compares with $4.10 as of November 28 and $3.68 at October 31. ■

CES FOUNDATION

CONTRIBUTIONS—NOVEMBER AND DECEMBER 1980

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for November and December 1980.

NOVEMBER

Unrestricted

Outagamie County Medical Society Auxiliary; SMS Members—*Voluntary Contributions*

Memorials

Mr-Mrs HB Maroney II: *Micki Hosig (Barbara Scott Maroney Diabetes Research Fund)*

Reese & Mavis Minor—*Mrs Rosaria Caravello (Barbara Scott Maroney Diabetes Research Fund)*

June & Mitchell Mackey—*HW Carey, MD (CG Reznichek, MD Student Loan Fund)*

Mrs Cyrus G Reznichek & Family—*Mrs Domenica Ginghello; Anton A Reznichek; Major John Krueger (CG Reznichek, MD Student Loan Fund)*

Dr-Mrs Gerald C Kempthorne—*Mrs Thelma Johnson*

Dr-Mrs Charles J Picard; Mr-Mrs Earl R Thayer—*Milton Finn, MD*

Dr-Mrs Kenneth Bauman: Mr-Mrs Earl R Thayer—*HW Carey, MD*

M Elnora Hayes Johnson & Family—*Aleda Schroeder*

State Medical Society—*John M Bell, MD; John D Owen, MD; Ernest G Oritz, MD; Charles E Pechous Sr, MD*

DECEMBER

Unrestricted

Auxiliary to the LaCrosse County Medical Society; Arabel & Robert B Murphy; SMS Members; MDs Margaret Prouty; Orvin G Glesne; Louis S Stern; Wm A Dafoe; Paul B Anderson; AA Holbrook; Margaret C Winston; Ervin Hansher; Alvin J Dupont; Jacob M Fine; Ralph O Kennedy; John E Conway; John W Berger Jr; Gordon W Brewery; Marriott T Morrison; John C Docter; Paul B Mason; Wilson J Troup; FW Madison; David L Nelson; Harry R Weil; Lon D Babbitt; HA Dasler; WR Byrne; FL Whitlark; D Schroeder Jr; Rocco LaTorraca; Hart E VanRiper; Myron Schuster; Morrison Schroeder; John A Thranow Jr; Michael G Marra—*Voluntary Contributions*

Restricted

Marathon County Medical Society Auxiliary—*Marathon County Medical Society Auxiliary Student Loan Fund*

Merck & Company, Inc—*Madison-In Depth Teaching Seminar; Speakers Service, July-December*

State Medical Society—*Museum of Medical Progress*

L Wayne & Marion Brown—*Medical Student Summer Externship Program*

Thomas W Tormey Jr, MD—*Tormey Memorial Medallion Fund*

Dorothy P Reinhardt—*Aesculapian Society Dues-1981*

Mr-Mrs Earl R Thayer—*Museum of Medical Progress Endowment Fund*

Memorials

Dr-Mrs Charles J Picard—*Ralph Anderson, MD*

State Medical Society—*John D Charles, MD; Michael E Korns, MD; Mrs Wm Howe*

Dr-Mrs Richard Edwards—*Keith McDougal, Jr*

Mr-Mrs L Wayne Brown—*Harold Borenz, MD*

Dorothy P Reinhardt—*Mrs Wm Howe*

Dr-Mrs EJ Nordby—*Henry Okagaki, MD*

Mr-Mrs Earl R Thayer—*Grant Boothroyd*

Bob & Jane Schmidt; Mr-Mrs JH Feldmann, Jr; Auxiliary to Brown County Medical Society; Dr-Mrs Wallace MacMullen; Dr-Mrs Robert E Johnson—*Marguerite Myers (Brown County Loan Fund)*

Mr-Mrs Bernard Bartel—*Mrs Wm Howe (Museum of Medical Progress Endowment Fund)*

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Eau Claire-Dunn-Pepin County Medical Society Auxiliary—*Mrs. Harold Sorensen*

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State Medical Society—*HW Carey, MD; Robert E Flynn, MD*

Dr-Mrs Larry Lemanski; Mr-Mrs Robert Conlin—*HW Carey, MD*

Mrs RW Burns—*Richard Myers; Mr OA Bodemer (Brown County Loan Fund)*

Wayne M Rounds—*G Maloof, MD* ■

Membership Directory UPDATE

Prepared from the February 26, 1981 Membership Report and from member notifications to Wisconsin Medical Journal for updating the 1980-81 Membership Directory

ASHLAND-BAYFIELD-IRON

Specialty changes

New	*Old*
GS VS **Teoh, Ivan**	GS CDS
OTO HNS **Hamp, James A**	OTO

BARRON-WASHBURN-BURNETT

New members	*Reelected members*
GS **Koob, Lynn D** 1020 Lakeshore Dr Rice Lake WI 54868	FP A1 **Beehner, Michael L** 1020 Lakeshore Dr Rice Lake WI 54868

BROWN

New members

IM CD
Fuchs, Matthias A
704 S Webster Ave
Green Bay WI 54301

CHIPPEWA

Removed from membership

Harrison, Les
Paulson, Steven G

DANE

New members	*Reelected members*
PM PMR **Halpern, Daniel** E3/350 CSC 600 Highland Ave Madison WI 53792	IM **Dally, Alfred D** 2138 Rowley Ave Madison WI 53705

Address changes

New	*Old*
PTH **Caceres, Victor W** 36 South Brooks St Madison WI 53715	38 South Brooks St
OBG **Crumpacker, Margaret** Box D 410 2065 Half Day Rd Deerfield IL 600 5	Deerfield IL 46383

Add member omitted

SCIENTIFIC FELLOW
Berman, Alvin L (PhD)
1014 Beloit Ct
Madison WI 53705

Specialty/address changes

New	*Old*
N **Zerofsky, Ronald A** 20 South Park St Madison WI 53715 (608) 255-4826	N IM 7318 Harvest Hill Rd Madison WI 53717 (addition)

Removed from membership

Alter Jr, Albert J
Froelich, Ralph D
Green, Joseph M
Myerowitz, P David
Renner, John H
Rowe, George G

Deceased members

Sprague, John T—Feb 23, 1981

DODGE

New members

GS CDS
Ali, M Ahmad
130 Warren St, #102
Beaver Dam WI 53916

Specialty changes

New	*Old*
FP **Damon, Richard A**	GP

DOUGLAS

New members

OBG **Meyer, Douglas R** 3600 Tower Ave Superior WI 54880	FP **Stephenson, Jon C** 318 21st Ave, East Superior WI 54880

Removed from membership

Thompson, Roger T

EAU CLAIRE-DUNN-PEPIN

Address changes

New	*Old*
P **Kimmel, Marco T** PO Box 1004 Eau Claire WI 54702	2712 Stein Blvd Eau Claire WI 5470I

Removed from membership

Raymond, Lou A

FOND DU LAC

Specialty changes

New	*Old*
PD **Koll-Frazier, Jane H**	PD P

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Fond du Lac 54935
(414) 922-3200

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First Wisconsin Bank
of Green Bay
425 Pine Street
Green Bay 54305
(414) 432-0321

MADISON—James E. Sugar
First Wisconsin National
Bank of Madison
First Wisconsin Plaza
Madison 53707
(608) 252-4157

MILWAUKEE—Philip A. Hardacre
First Wisconsin Trust Company
777 East Wisconsin Avenue
Milwaukee 53202
(414) 765-5080

OSHKOSH—Wilson K. Roane
First Wisconsin National
Bank of Oshkosh
111 North Main Street
Oshkosh 54903
(414) 424-4200

RHINELANDER—Robert A. Schultz
First Wisconsin Trust Company
(Trust Services Office)
First National Bank of Rhinelander
8 West Davenport Street
Rhinelander 54501
(715) 362-6900

WAUSAU—Robert A. Schultz
First Wisconsin National Bank
of Wausau
400 Scott Street
Wausau 54401
(715) 845-1125

WISCONSIN RAPIDS—Philip L. Dunmire
First Wisconsin Trust Company
(Trust Services Office)
First National Bank of Wisconsin Rapids
311 West Grand Avenue
Wisconsin Rapids 54494
(715) 424-1788

FWT-24G-E-K

GRANT

Address changes

New	*Old*
GP **Taylor Jr, Harold W** 207 East Skelly St Cuba City WI 53807	PO Box 593

GREEN

Specialty changes

New	*Old*
IM CD **Tullett, Geoffrey L**	IM

JUNEAU

New Members

FP
Radant, Leon J
205 Division St
Mauston WI 53948

Address Changes

New	*Old*
FP **Ness, D Keith** 1040 Division St Mauston WI 53948	205 Division St
FP **Ness, Nancy E B** 1040 Division St Mauston WI 53948	205 Division St
GP **Strong, Jack** 1040 Division St Mauston WI 53948	143 Division St

KENOSHA

Address changes

New	*Old*
IM HEM **Knight, Raymond W** 1015 65th St Kenosha WI 53140	6530 Sheridan Rd

LA CROSSE

New members

IM CD
Goren, Carolyn C
1836 South Ave
La Crosse WI 54601

Removed from membership

Boyd, William C
Johnson, Gordon L
Norenberg, David D

County society transfers

Park, Tai J — to: Winnebago

Address changes

New	*Old*
FP **Engel, Charles H** 436 W Franklin West Salem WI 54669 (608) 786-1560	134 N Leonard St (addition)
OBG **O'Leary, William J** 1118 Seiler La La Crosse WI 54601 (608) 788-3018	 (addition)
IM GE **Oliai, Asghar** 3160 Elm Dr La Crosse WI 54601 (608) 788-3311	 2110 Wedgewood Dr (addition)
OPH **Skemp, Samuel J** 212 S 11th St La Crosse WI 54601 (608) 784-3050	 815 S 10th St (addition)

Specialty/address changes

New	*Old*
PD NPM **Kechavarz, Lida** 815 S 10th St La Crosse WI 54601 (608) 782-9760	PD N **Oliai, Lida Kechavarz**

Specialty changes

New	*Old*
HEM IM **Keimowitz, Rudolph M**	OS IM

MANITOWOC

New members

IM **De Bruyn, Donald J** 601 Reed Ave Manitowoc WI 54220	IM **Govier, Mary N** 601 Reed Ave Manitowoc WI 54220
U **Stern, John M** 220 E Cleveland Ave Manitowoc WI 54220	

Address changes

New	*Old*
P N **Kadile, Eleazar M** 021 E Waldo Blvd Manitowoc WI 54220	 115 E Waldo Blvd
P N **Kadile, Hermengildo** 021 E Waldo Blvd Manitowoc WI 54220	 115 E Waldo Blvd
PD **Thorpe, Robert F** PO Box 279 Manitowoc WI 54220	 601 Reed Ave

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and only a physician—only a professional diagnosis—can establish the etiology for a given patient. Then, if Conditioned Response Therapy is indicated, an Enuresis Alarm is best used under the physician's guidance. This is why S & L Enuresis Alarms are rented to patients **on prescription only.** S & L is the only nation-wide alarm rental service whch restricts itself to **prescription** rentals.

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MARINETTE-FLORENCE

New members

PED FP
Hofmann, Michael P
Pound WI 54161

1M
Mertens, David R
1510 Main St
Marinette WI 54143

FP OBG
Worden, Leonard R
1510 Main St
Marinette WI 54143

MARATHON

Address changes

New	*Old*
GP **Han, Paul Z** PO Box 1446 Wausau WI 54401	1008 McIndoe St
GS **Muehlenbeck, Erich C** 2800 Westhill Dr Wausau WI 54401	2807 N Seventh St

MILWAUKEE

Address changes

New	*Old*
AN **Burchman, Sheldon L** 226 N Prospect Ave Milwaukee WI 53202	250 West Bergen Ct Milwaukee WI 53217
IM **Costello, Addis C** 647 N 79th St Milwaukee WI 53213	811 E Wisconsin Ave Milwaukee WI 53202
IM **Hanauer, Margaret M** N1 W25042 Northview Rd Waukesha WI 53186	1040 Lower Ridgeway Elm Grove WI 53122
IM **Lo, Romeo C** 2040 W Wisconsin Ave, #780 Milwaukee WI 53233	2460 West Vliet St Milwaukee WI 53205
P **Patterson, Richard H** 4110 West Martin Dr Milwaukee WI 53208	3070 N 51st St Milwaukee WI 53210
1M GE **Robinson, James E** 2040 W Wisconsin Ave, #780 Milwaukee WI 53233	2460 West Vliet St Milwaukee WI 53205
GP **Shirke, Shaila R** 5231 W Villard Ave Milwaukee WI 53218	5615 W Hampton Ave

Specialty/address changes

New	*Old*
D DMP **Kersting, David W** PO Box 11-0 Milwaukee WI 53201 (414) 344-9400	D OS PO Box 26509 Milwaukee WI 53226
1M PUD **Mathai, George** 13450 Dunwoody Dr Elm Grove WI 53122	IM PO Box 11-0 Milwaukee WI 53201

Specialty changes

New	*Old*
1M NEP **Means, James A**	IM OS
PYA P **Black, Samuel B**	P

Reinstated members

CRS **Charles, John D** 6558 N 52 St, c/o Lasky Milwaukee WI 53233	IM **Field Jr, Brenton H** 3003 W Good Hope Rd Milwaukee WI 53209

Removed from membership

Nemeth, Charles
Theil, George B

Deceased members

Thatcher, Donald S—Oct 27, 1979
Howell, Arthur—Jan 26, 1981

ONEIDA-VILAS

Address changes

New	*Old*
FP **Houlihan, James T** 240 Maple St, PO Box 470 Woodruff WI 54568	(addition)

OUTAGAMIE

Address changes

New	*Old*
IM **Butitta, John M** 1501 S Madison St Appleton WI 54911	401 N Oneida St
IM **O'Boyle, Robert F** 3200 N Lakeshore Dr, #2706 Chicago IL 60647	401 N Oneida St Appleton WI 54911

Reinstated members

P PN
Belden, Allan D
610 E Longview Dr
Appleton WI 54911

Removed from membership

Todd, Jean

Deletion

Finch, David R (member of Winnebago CMS, erroneously listed in Outagamie CMS)

POLK

Address changes

New	*Old*
FP	
Elbing, Paul F	
127 N Keller Ave	126 Burman Ave
Amery WI 54001	

PRICE-TAYLOR

New members

GP	GP
Cameron, Vinoo	**Robinson II (DO), James K**
101 W Gibson Ave	101 N Gibson Ave
Medford 54451	Medford WI 54451

Removed from membership

Schoenfeld, Paul M

RICHLAND

Address changes

New	*Old*
IM	
Sinnett, Dale F	
Rte 4	Rte 2, Box 32A
Richland Center WI 53581	

ROCK

New members

IM	DR R
Ajdukovich, Craig S	**Hatch, James L**
5 West Rollin St	1029 Parkridge Rd
Edgerton WI 53534	Janesville WI 53545

IM
Zajac, Dorothy J
60 South River St
Janesville WI 53545

Reelected members

GS S
Karzel, Ronald P
580 N Washington St
Janesville WI 53545

SAUK

New members

FP
Koontz, Robert J
1900 N Dewey Ave
Reedsburg WI 53959

Specialty/address changes

New	*Old*
FP	GP
Galarnyk, Ihor A	
Plain WI 53577	
(608) 546-4211	(addition)

SHAWANO

Removed from membership

Carlson, William J
Kurtz, Curtis G

SHEBOYGAN

Address changes

New	*Old*
PTH	
Dick, Herman J	
%RC Gries, 629 Torrey Pl	#5 2732 N 10th St
Goleta CA 93117	Sheboygan WI 53081
GP	
Jackson, Thomas V	
4230 Senneth Ave	PO Box 93
McFarland WI 53558	Plymouth WI 53073

Deceased members

Heiden, Harry H—Jan 17, 1981

WALWORTH

Address changes

New	*Old*
GS	
Seegers, James V	
104 S Wisconsin St	
Elkhorn WI 53121	Walworth WI 53184

WASHINGTON

New members

R NM
Sherkow, Larry H
5644 Colleen Lane
West Bend WI 53095

WAUKESHA

New members

OBG	IM PUD
Halverson, Gloria M	**Herrell, Daniel W**
18590 Anita Dr	W180 N7950 Town Hall
Brookfield WI 53005	Menomonee Falls WI 53051
OBG	PTH
Maker, George E	**Rykwalder, Paul J**
915 Summit Ave	W180 N8085 Town Hall
Oconomowoc WI 53066	Menomonee Falls WI 53051

Address changes

New	*Old*
FP	
Rosenkranz, Wilbur E	
225 Eagle Lake Ave	720 N Rochester St
Mukwonago WI 53149	

Reelected members

FP
Zarbock, Floyd M
S89 W22915 Maple St
Big Bend WI 53103

WINNEBAGO

New members

FP
Hay, Darrell E M
323 Jefferson Ave
Omro WI 54963

PTH
Shuffstall, Richard M
410 Dewey Ave
Wisconsin Rapids WI 54494

County society transfers

Park, Tai J
130 Second St
Neenah WI 54956 — from: La Crosse

Specialty changes

New	*Old*
PS HS	GS PS

Finch, David R

WOOD

Address changes

New	*Old*
AN	
Burns Jr, John L	
600 Maryknoll Ave	1000 North Oak Ave
Marshfield WI 54449	
IM GE	
Manier, James W	
Univ Medical Center	Rt 4 Sugarbush Lane
Morgantown WV 26506	Marshfield WI 54449

Removed from membership

Manier, James W ■

County Societies

*Physician members of State Medical Society of Wisconsin

ADAMS-MARQUETTE-COLUMBIA. The Tri-County Medical Society has established a policy to exempt members who are over age 70 years from payment of county dues. The County Society also approved a resolution on unified membership to be forwarded to the SMS House of Delegates. The resolution proposed discontinuation of unified membership, favoring individual freedom of choice in membership.

CHIPPWA: New officers of the Chippewa County Medical Society are: MDs Romeo B Sangalang,* Chippewa Falls, president; Bruno Rahn,* Chippewa Falls, vice-president; and Richard D Kennedy,* Eau Claire, secretary-treasurer. Merne Asplund, MD* of Bloomer was named delegate and John Sazama, MD* of Chippewa Falls, was named alternate delegate to the State Medical Society.

KENOSHA: Kenosha County Medical Society officers for the year 1981 are MDs James Bennett,* Kenosha, president; and Anoo Patel,* secretary. Elected as delegates to the State Medical Society of Wisconsin are Clifford Peterson,* Joyce Yerex,* and Meredith Clubb.* Alternate delegates are Raymond Knight,* Raymond Witt,* and Simeon Ortiz.* Doctor Bennett has been practicing in Kenosha since 1973 and succeeds John Richards, MD* as president.

KENOSHA: The Kenosha County Medical Society in December gave $500 to the State Medical Society's CES Foundation in memory of Charles E Pechous Sr, MD who died September 13, 1980.

KENOSHA: State Medical Society Secretary Earl R Thayer addressed members of the Kenosha County Medical Society at its meeting January 18 in Kenosha. He presented a general overview of SMS activities during the year 1980.

MARATHON: The Marathon County Medical Society Auxiliary in December contributed $1,110.75 to the Student Loan Fund of the State Medical Society's CES Foundation.

MILWAUKEE: The Medical Society of Milwaukee County honored eight of its members during the Society's Annual Membership Meeting December 11. Distinguished Service Awards for outstanding contribution to the medical community were presented to MDs George H Lane* for his pioneer work with sickle cell anemia, Walter P Blount* and Albert C Schmidt* for their development of the Milwaukee Brace, Joseph C Darin* for his development of the Milwaukee County Paramedic Program, Harold D Itskovitz* and Constantine Panagis* for developing a model hypertension screening program in Milwaukee, H Myron Kauffman* for his pioneer work in kidney transplants, and Mortimer C Bortin* for his research efforts into bone marrow transplants.

Also presented 50 Year Awards were MDs Donald C Ausman,* Milton C Borman,* Harold E Cook,* Norbert F Dettmann,* Arne C Gorder,* John B Hitz,* Carroll W Osgood,* Benjamin E Urdan,* William B Walton,* and John F Wyman.*

OUTAGAMIE: Dennis Maki, MD of the University of Wisconsin Medical School, Madison, spoke to the Outa-

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All information is preprogrammed to be compatible with reporting requirements of government agencies and private health carriers including daily Insurance forms. Once a month, each doctor's office receives itemized Super Bills ready for mailing.

Prognosis:
The DocBill system is a proven system that can save you hours of time, countless headaches, and thousands of dollars previously spent on bookkeeping expenses. The system can be utilized by virtually anyone in the medical health care field.

Prescription:
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gamie County Medical Society January 15 on "The current state of the art relative to the use of antibiotics."

POLK: At a recent meeting of the Polk County Medical Society Dr Stephen McCue presented a paper entitled "The Abnormal Pap Smear and Colposcopy." Election of officers also was held. William R Byrne, MD,* Amery, was elected president; William W Young, MD,* St Croix Falls, was elected secretary; and Marwood E Wegner, MD,* St Croix Falls, delegate, and John O Simenstad, MD,* Osceola, alternate delegate to the State Medical Society.

POLK: Dr Will Corson of the St Louis Park Medical Center in Minneapolis, Minn addressed the Polk County Medical Society January 15 on the subject "New advances in pulmonary medicine."

ROCK: Robert Durkin of the Wisconsin Department of Health and Social Services was guest speaker at a recent meeting of the Rock County Medical Society. His current area of responsibilities includes overseeing the Health Planning Council's activities. He formerly was involved in the State's Medicaid program.

Mr Durkin expressed his opinion that the recent conservative swing and elections may indicate some changes in the immediate future but that "massive" government intervention in medicine will continue. He urged caution in enthusiastic acceptance of new programs which may turn out to be less desirable to the medical community than the old programs. Mr Durkin stated several reasons why health planning is important. He said that Wisconsin Medicaid expense is now $750 million a year and should exceed one billion dollars a year within the next two years. As an example of a tremendous medical expense and the growth of medical expense, he noted that costs for renal dialysis for end-stage kidney disease in the United States were $160 million in 1974, $850 million in 1979, and should grow to $2.6 billion in the very near future if the present rate of growth continues. Private corporation health expenditures are reaching astronomical proportions, he noted. The TRW Corporation spends 45% of its net income on employee health benefits, he said. General Motors estimates the health benefits of its employees at $200 per automobile produced.

Since appropriate health planning involves the private sector, Mr Durkin said that physicians are in a unique position to become involved and be participants in the medical society, health systems agencies, and the state Health Planning Council.

In digressing somewhat Mr Durkin said the Wisconsin Medicaid program is the tenth largest in the United States, far out of proportion from a population point of view, but that the State Legislature has been very generous and has taken all optional programs resulting in horrendous and unnecessary expenses, providing unnecessary and unjustified levels of healthcare to the Wisconsin Medicaid recipients. He said Wisconsin Medicaid recipients received the most expensive and the most comprehensive and, in fact, the best health insurance available anywhere in the United States from either the private or public sector. He also noted that physician fees account for less than 6% of the total Medicaid cost. He also pointed out the fact that administrative costs of the Wisconsin Medicaid program are less than 4% and that this is the lowest in the United States.

WINNEBAGO: Leroy A Johnson, director of administrative services of the State Medical Society, spoke to members of the Winnebago County Medical Society at the January 15 meeting. He explained benefits of membership in the State Medical Society. ■

Make SMS videotape the highlight of your next meeting

Want to get a clear, concise, and thorough overview of the State Medical Society of Wisconsin, how it functions, its programs, and activities? Then schedule the newly released videotape *The SMS: A Look From The Inside* for your next county society, medical staff, or specialty society meeting. The videotape is available on three-quarter inch tape. To schedule the program for your next meeting, and to obtain information on where videotape playback equipment may be rented in your area, contact Mike Brozek at SMS headquarters in Madison at 608/257-6781 or call toll-free 800/362-9080.

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Cutter Biological
Division of Cutter Laboratories, Inc.
Berkeley, California 94710
See next page for brief summary of prescribing information.

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DESCRIPTION

Rabies Immune Globulin (Human)—Hyperab® is a sterile solution of antirabies gamma globulin (IgG) concentrated by cold alcohol fractionation from plasma of donors hyperimmunized with rabies vaccine. Hyperab® globulin is a 16.5% ± 1.5 solution of gamma globulin from venous blood in 0.3M glycine, preserved with 1:10,000 Thimerosal (a mercury derivative). Its pH is adjusted with sodium carbonate. The product is standardized against USA Standard Antirabies Serum. The USA unit of potency is equivalent to the International Unit (IU) for rabies antibody.

This product is prepared from human venous plasma. Each individual unit of plasma has been found nonreactive for hepatitis B surface antigen using the radioimmunoassay method of counter-electrophoresis.

INDICATIONS

Treatment of rabies, once clinical disease becomes apparent, is rarely if ever successful. Rabies vaccine (duck-embryo origin, Lilly Laboratories) with or without Rabies Immune Globulin (Human)—Hyperab® should, therefore be given to all persons suspected of exposure to rabies, particularly to severe exposure. Whenever possible, Hyperab® globulin should be injected as promptly as possible after exposure. If initiation of treatment is delayed for any reason, however, Rabies Immune Globulin (Human) should be given just the same, regardless of the interval between exposure and treatment.

Rabies virus is usually transmitted by the bite of a rabid animal, but can occasionally penetrate abraded skin with the saliva of infected animals. Progress of the virus after exposure is believed to follow a neural pathway, and the time between exposure and clinical rabies is a function of the proximity of the bite (or abrasion) to the central nervous system and the dose of virus injected. The incubation is usually 2 to 6 weeks, but can be longer. After severe bites about the head and neck, it may be as short as 10 days.

After initiation of the vaccine series, it takes 2 weeks or longer for development of immunity to rabies. Since most vaccine failures have occurred in cases of severe exposure, the value of immediate immunization with preformed rabies antibody cannot be over-emphasized.

Recommendations for use of passive and/or active immunization after exposure to an animal suspected of having rabies were detailed by WHO, and by the US Public Health Service Advisory Committee on Immunization Practices (ACIP).

INJECTION PROCEDURE

A portion of the Hyperab® globulin dose should be used to infiltrate the wound. The rest is injected intramuscularly.

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Rabies Immune Globulin (Human)—Hyperab® is contraindicated in repeated doses, once vaccine treatment has been initiated. Repeating the dose may bring about interference with full expression of active immunity expected from the vaccine. Hyperab® globulin is also contraindicated in individuals who are known to have an allergic response to gamma globulin or thimerosal.

PRECAUTIONS

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Slight soreness at the site of injection, and slight temperature elevation, may be noted at times. Sensitization to repeated injections of human globulin is extremely rare.

In the course of routine injections of a large number of persons with human gamma globulin, there have been a few isolated occurrences of angioneurotic edema, nephrotic syndrome, and anaphylactic shock after injection. Because of their rarity, it is difficult to determine whether such reactions are incidental, or causally related to the gamma globulin.

No instances of transmission of hepatitis B (homologous serum jaundice) have been reported from the use of human gamma globulin prepared by the fractionation methods employed by Cutter Laboratories, Inc.

HOW SUPPLIED

Rabies Immune Globulin (Human)—Hyperab® is packaged in 2-ml. and 10-ml. vials with a potency of 150 International Units per ml. (IU/ml.). The 2-ml. vial contains a total of 300 IU which is sufficient for a child weighing 15 kg. (33 lb.). The 10-ml. vial contains a total of 1500 IU which is sufficient for an adult weighing 75 kg. (165 lb.).

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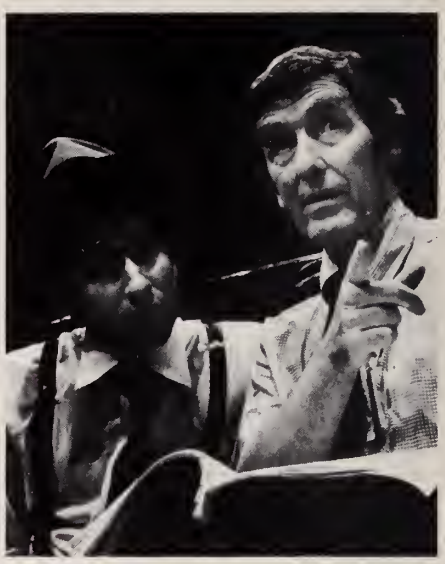

GREGORY FALLS

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Career: Artistic Director

Age: 57

Married: Four children

Interests: Drama, writing, travel and volunteering for United Way

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American Council of Otolaryngology and American Academy of Otolaryngology have changed their names to The American Council of Otolaryngology—Head and Neck Surgery and the American Academy of Otolaryngology—Head and Neck Surgery. These two medical specialty societies represent more than 5,000 otolaryngologists in the United States. During the past 50 years, otolaryngology has evolved from a specialty which had within its purview the common medical and surgical problems of the ear, nose, and throat—largely of infectious or allergic origin, into a regional specialty which has special competence in dealing with the medical and surgical disorders of the head and neck excluding the brain and the eye. As otolaryngology expanded into a regional specialty, the need for additional training became apparent. Beginning in 1981 an approved otolaryngology training program must include, among many other things, training in head and neck cancer surgery and regional reconstructive and cosmetic plastic surgery. Otolaryngology is the second oldest specialty and becomes the fourth of the 22 medical specialties to require five years training, according to Harry W McCurdy, MD, executive director of The American Council of Otolaryngology—Head and Neck Surgery, Suite 602, 1100-17th Street NW, Washington, DC 20036 (phone: 202/659-4591).

The Wisconsin Chapter, American College of Surgeons was inadvertently omitted from our listing in the June 1980 Blue Book issue of the Journal. The following MDs are officers: Bruce Stoehr,* 1551 Dousman, Green Bay 54303, president; Paul Fox,* W229 S4340 Milky Way, Waukesha 53186, secretary-treasurer; and Joseph D Lewis,* 297 South 17th St, West Bend 53095 is the president-elect.

American College of Physicians, Philadelphia, has selected Ruth A Rabinovitch, MD, Milwaukee, as one of 13 Midwestern residents to present a paper during a special session at its convention in Kansas City, Mo, in April. Doctor Rabinovitch will be representing the Medical College of Wisconsin, Milwaukee, and her paper is entitled "Fever With Chest and Shoulder Pain." Chosen from young physicians in training programs at medical centers within a 500-mile radius of Kansas City, Doctor Rabinovitch's presentation is based on her original observations and experiences during her training.

Wisconsin Chapter, American Academy of Pediatrics is holding its Annual Scientific Program on May 8-9, 1981 at the Pioneer Inn in Oshkosh. The theme is Ambulatory Pediatrics and the keynote speaker is Barbara Korsch, MD, Children's Hospital of Los Angeles. Frank Stiles, MD of the Monroe Clinic, Monroe is the program chairman. ■

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JCAH physician surveyors needed

The Joint Commission on Accreditation of Hospitals (JCAH), a private, not-for-profit organization, is seeking the State Medical Society's assistance in its search for physician surveyors who are interested in helping hospitals throughout the country provide the highest possible level of health-care services through education, evaluation, and consultation.

Janet L Heckman, manager of compensation and employment, offers the following information:

The JCAH physician survey team member is responsible for a broad spectrum of activities. Evaluation of hospital medical staff functions and quality assurance activities and evaluation of anesthesia, dental, emergency, nuclear medicine, pathology, radiology, and medical records services are examples of the comprehensive scope of the survey process.

Qualifications for this position include current medical licensure; extensive clinical and patient care management experience; at least 10 years of service on a hospital medical staff; strong oral and written communications skills; excellent physical health; and, a strong desire to participate in this voluntary national quality assurance process.

The JCAH's compensation package includes a good base salary, nontaxable per diem expenses and liberal automobile mileage allowance. Noncontributory life insurance, medical insurance and retirement plan plus an optional tax-sheltered annuity plan are also included.

We would greatly appreciate the State Medical Society's help in providing this information to physicians seeking employment opportunities. All interested candidates are invited to call for additional information (312/642-6061, ext 333), or send their resume to Janet L Heckman, Joint Commission on Accreditation of Hospitals, 875 North Michigan Ave, Chicago, Ill 60611.

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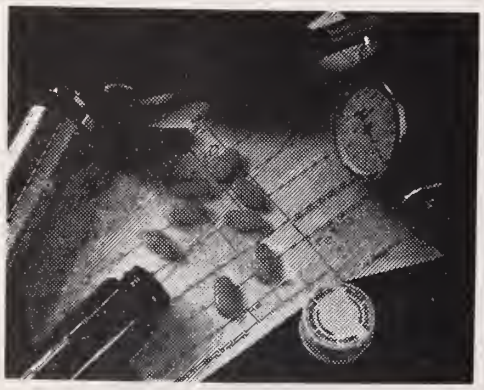

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Physician Briefs

*Physician members of State Medical Society of Wisconsin

Alan Cherkasky, MD, Kaukauna, recently became associated in medical practice with his father, Simon Cherkasky, MD.* Doctor Alan Cherkasky graduated from Chicago Medical School and served an internship and residency at Baylor College of Medicine, Houston, Tex. Further residency was completed in family practice at the University of Texas. While in Texas, Doctor Cherkasky became the Houston Astros' assistant to the trainer, which involved taking care of the team's collective aches, pains, and injuries. He also served as a surgeon on the "Life Flight" team which was a trauma team dispatched by helicopter in the Houston area.

R Scott Liebel, MD,* Woodruff, recently joined the medical staff at Eagle River Memorial Hospital. A board certified surgeon, he is associated with Everett C Eickhoff, MD* in Land O'Lakes, the Kalmar Clinic, Eagle River, and the Walter Olson Clinic in St Germain. He graduated from the Medical College of Wisconsin, Milwaukee, and served his internship and residency at West Virginia University Hospital, Morgantown. He previously had practiced with the Lakeland Medical Associates in Woodruff.

Adrian Bourque, MD, a radiation therapist, recently became associated with the Wausau Medical Center. Doctor Bourque graduated from Creighton University School of Medicine, Omaha, Neb, where he completed his residency in general radiology. His residency in radiation therapy was completed at the University of Wisconsin Hospital and Clinics in Madison.

Fred A Rosenblum, MD, recently became associated with East Towne Medical Associates in Port Washington and Milwaukee. Doctor Rosenblum is an internist and graduated from Jefferson Medical College in Philadelphia. His internship and residency were completed at the University of Wisconsin Medical School in Madison. He is joining internists Burton A Waisbren Jr, MD,* cardiologist; Allen H Schaeffer, MD, cardiologist, and Garland W Yarborough, MD, a gastroenterologist.

Richard Christianson, MD, Portage, recently joined the medical staff of Divine Savior Hospital. Doctor Christianson graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency at Ball Memorial Hospital, Muncie, Ind.

Mary B Scheurich, MD,* LaCrosse pediatrician, recently assumed the presidency of the medical staff of St Francis Medical Center. Fred C Skemp Jr, MD,* family practitioner, was elected secretary-treasurer; and Charles E Link, MD, internal medicine, is president-elect.

Dorothy Zajac, MD, an internal medicine specialist, recently opened her office in Janesville. She graduated from Creighton University Medical School, Omaha, Neb, and served an internship at Cook County Hospital, Chicago. Her residency was completed at the Cleveland Clinic. Prior to coming to Janesville, Doctor Zajac was associated with a medical group in Sun Prairie. She earned the American Medical Association's Physician's Recognition Award in 1978, and is a diplomate of the National Board of Medical Examiners.

Sheilia Sorkin, MD, Evansville, recently opened her medical clinic. She graduated from Northwestern University School of Medicine and served her internship at Wesley Memorial Hospital in Chicago. She practiced at the Valparaiso University Health Center and also spent two years in the emergency department in Porter Memorial Hospital in Valparaiso, Ind. While in Valparaiso, Doctor Sorkin maintained her own medical practice for six years.

Michael McCormick, MD,* Waukesha, recently was appointed to serve as a public member on the Radiation Protection Council. A clinical instructor in ophthalmology at the Medical College of Wisconsin, Doctor McCormick is president-elect of the Waukesha County Medical Society, and secretary-treasurer of the Wisconsin-Upper Michigan Society of Ophthalmology.

Philip F Winskunas, MD, Chippewa Falls, recently was named to the medical staff at St Joseph's Hospital. Doctor Winskunas is associated in practice with Caesar R Gonzaga, MD.* He graduated from Stritch School of Medicine, Loyola University, Maywood, Ill, and served his residency at New York University Hospital and Cook County General Hospital in Chicago.

John F Holmes, MD,* Milton (right above) is shown receiving an engraved Golden House Clock from his son, John C Holmes (left), who is sales representative of Abbott Laboratories. Abbott Laboratories presented the clock in commemoration of Doctor Holmes' retirement from his medical practice of 34 years in Milton. ■

Obituaries

✓County, State, and AMA members

✓**Donald S Thatcher, MD,** 69, Milwaukee physician for 30 years, died Oct 27, 1979 in Port St Lucie, Florida. Born March 30, 1915, Doctor Thatcher graduated from Marquette University School of Medicine in 1940 and served his internship and residency at Milwaukee County General Hospital. He served in the United States Army Medical Corps from 1941-1946. Doctor Thatcher had been chief-of-staff at Lutheran Hospital, Milwaukee, and also had been a lifetime supporter of the Visiting Nurse Association in Milwaukee, serving as its medical director from 1971-1976. Surviving is his widow.

✓**Marvin Wright, MD,** 72, Rhinelander, died Dec 28, 1980 in Green Valley, Ariz. Doctor Wright was born June 6, 1908 in Des Moines, Iowa, and graduated from the University of Iowa School of Medicine in 1936. He served his internship at Maine General Hospital, Portland, Maine. Prior to joining the Bump Medical Group in Rhinelander, Doctor Wright had practiced medicine in Newton, Ia. He retired from medical practice in 1975. Doctor Wright served as a councilor of the 13th district from 1962-1971 to the State Medical Society of Wisconsin; he was a charter member of the American College of Obstetricians and Gynecologists and also had served as chief-of-staff at St Mary's Hospital in Rhinelander. Surviving are his widow, Helen; three daughters, Mrs. Thomas (Sarah) Gillespie, Oshkosh; Mrs Fred (Jane) Erickson; and Miss Margaret Wright of Topeka, Kan.

✓**Edward D Wilkinson, MD,** 85, West Allis physician for 39 years, died Jan 6, 1981 in Elm Grove, Wis. Born Apr 29, 1895 in Delafield, Wis, Doctor Wilkinson graduated from Marquette University School of Medicine in 1929 and served his internship at Milwaukee County General Hospital. His residency was completed at the University of Vienna, Austria. Doctor Wilkinson retired from medical practice in 1970 and in 1979 he became a member of the "50 Year Club" of the State Medical Society of Wisconsin. Surviving are three sons; Edward J, Gainesville, Fla; Michael T, West Allis, and James V of Brookfield.

✓**Thomas C Norris, MD,** 32, Onalaska, died Jan 8, 1981 in Onalaska. Born Mar 20, 1948 in Fond du Lac, Doctor Norris graduated from the University of Wisconsin Medical School in Madison. He served his internship at LaCrosse Lutheran Hospital and the Gundersen Clinic. Doctor Norris became a member of the medical staff of the Gundersen Clinic in 1979. Surviving are his widow, Susan; a daughter, Kathryn, and a son, Robert.

✓**William W Grover Jr, MD,** 64, Bonduel physician since 1957, died Jan 10, 1981 in Bonduel. Born Aug 13, 1916 in Richmond, Va, Doctor Grover graduated from the University of Colorado School of Medicine, Denver, and served his internship at Parkland Hospital in Dallas, Tex. He was assistant professor of physics at both Washington and Lee University and at Virginia Military Institute, Lexington, Va. He was a clinical associate professor of medicine at the University of South Dakota at which time he also conducted private medical practice in Yankton, South Dakota. From 1957 until his death, Doctor Grover and his wife, Patricia Stuff, MD, were in joint private practice in Bonduel.

Active in numerous professional and civic organizations, he was on the Council of Shawano County Nutrition Program for Elderly; the Northeast Wisconsin Emergency Medical Services Council, serving on the Executive Committee of the Board of Directors; the Shawano County Health Systems Agency Advisory Committee. He was a board member of the Northeast Wisconsin Health Systems Agency, having served as president in 1978. He served thirteen years on the Bonduel Community School Board and was clerk of the Board at the time of his death.

Doctor Grover served as president of the Shawano County Medical Society in 1965, and was the Shawano County Medical Society alternate delegate for eight years and a delegate since 1974 to the State Medical Society. He was on the medical staff of the Shawano Community Hospital and had served as president. He was an adjunct professor at the University of Wisconsin-Oshkosh since 1975 and also was health officer for the village of Bonduel and the towns of Hartland and Lessor.

Doctor Grover had served as vice-chairman of the State Advisory Committee for the Wisconsin Regional Medical Program; served two terms as president of the Northeast Wisconsin Health Planning Council; and was chairman of the Shawano County Health Planning Committee. For five years he was president of the Shawano County Chapter of the American Cancer Society. He was a member of the American Chemical Society. He also was county coordinator for the Emergency Medical Technician Training Program and was on the Shawano County Emergency Medical Service Committee.

Surviving are his widow, Patricia; and three children, Sara Watt Grover, Thea Diehl Grover, and William Wesley III.

✓**Paul P Goodman, MD,** 70, Milwaukee, died Jan 12, 1981 in Milwaukee. Born June 22, 1910 in Milwaukee, Doctor Goodman graduated from the University of Wisconsin Medical School, Madison, and served his internship at Touro Infirmary in New Orleans, La. His residency was completed at Presbyterian Hospital, Chicago, Ill. Doctor Goodman served in the United States Army Medical Corps from 1941 until 1945. Surviving are his widow, Margaret; one daughter, Patricia Zimmerman, Manitowoc; and two sons, Dr John, Seattle, Wash; and Dr Lawrence of Houston, Tex.

✓**Harry H Heiden, MD,** 92, Elkhart Lake, a retired Sheboygan physician, died Jan 17, 1981. Born Apr 6, 1888 in Sheboygan, Doctor Heiden graduated from Marquette University School of Medicine in 1917. His internship was served at the Children's Hospital in St Louis, Mo. Doctor Heiden served in the United States

Army Medical Corps from 1940-46, and was the first Sheboygan physician to enter active military service during World War II. A founder of the Sheboygan Clinic, Doctor Heiden served as president for several years, and also served as president of the Sheboygan County Medical Society. He became a member of the "50 Year Club" of the State Medical Society of Wisconsin in 1972. Surviving are two daughters, Marion Heiden, Elkhart Lake, and Mrs Peter (Harriet) Kirchhoff of Brookfield.

John Rankin, MD, 57, Madison, died Jan 22, 1981 in Madison. Born Jan 29, 1923 in Glasgow, Scotland, Doctor Rankin graduated from the University of Wisconsin Medical School, Madison, and served his internship at University Hospital in Glasgow, Scotland. His residency was completed at Stobhill Hospital, Glasgow; Mayo Clinic, Rochester, Minn; and at the University of Pennsylvania. Doctor Rankin joined the University of Wisconsin Medical School faculty in 1953 and was chairman of the Department of Preventive Medicine at the time of his death. Surviving are his widow, Nancy, and three children.

Arthur Howell, MD, 54, Milwaukee, died Jan 26, 1981 in Milwaukee. Born Dec 24, 1926 in Concord, NC, Doctor Howell graduated from Howard University, Washington, DC in 1953. His internship was served at St Thomas Hospital in Akron, Ohio, and his residencies in plastic surgery were completed at Northwestern Medical School and Provident Hospital, Chicago, Ill. Surviving are his widow, Jacqueline; and two children. ■

VIGNETTE BOOK

The Aesculapian Society, the historical arm of the SMS's Charitable, Educational and Scientific Foundation, invites all readers to contribute a story or two about a deceased Wisconsin physician to the Vignette Book Project.

The book is a collection of warm, human interest-type sketches of deceased Wisconsin physicians. It emphasizes the personality of the doctor, not just medical and educational accomplishments—the sort of thing that can be found in any standard, official biography. True, some of the sketches have biographical information in them, but the main theme is the personality of the man or woman.

So far, the Vignette Book has more than 60 sketches in it, representing 29 counties. A true picture of Wisconsin medical history is gathered together in the book, from the medical school researcher to the country practitioner. The Aesculapian Society needs your help in filling out the rest of the story.

During the summer, the Vignette Book is kept at the Fort Crawford Medical Museum in Prairie du Chien; in the winter time, it can be read at Society headquarters in the Council Room.

If a reader would like more information on the project, or would like to write a vignette, please contact: Mrs Deborah Erwin (Chesley), 826 North 75th Street, Wauwatosa, Wisconsin 53213.

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
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Prolonged or excessive use of corticosteroids might produce systemic effects.
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Medical Assistants
MARCH 1981

ANNUAL MEETING: MAY 15-17

THE WISCONSIN SOCIETY of the American Association of Medical Assistants, Inc will hold its 26th Annual Meeting May 15-17, 1981 at the Holiday Inn, Fond du Lac, Wisconsin. Members of the Fond du Lac Chapter will host the event with the theme, "Light the Way with AAMA."

Governor Lee Dreyfus will be issuing a Proclamation declaring May 10-17 Medical Assistants Week in Wisconsin.

The preconvention Executive Board meeting will meet Friday morning, May 15, prior to the Reference Committee meeting at 10:30 am for study of the proposed one-document Bylaws to be presented at the afternoon House of Delegates. A Delegates Luncheon will precede the House of Delegates where the business of the Society will be conducted including the election of new officers.

For those guests not attending the House of Delegates a tour will be conducted of the Historic Galloway House and Village. Friday evening a family fun night is planned at Lakeside Park including a picnic and square dancing.

Saturday, May 16, will be devoted to educational sessions with CEUs (Continuing Education Units) being awarded to those successfully passing the examinations following each presentation. A formal welcome will be given to the group by President Carol Wiesner, CMA and a representative from the City of Fond du Lac. The two-hour morning program will be devoted to "Time Management" presented by Mr Virgil Staples, New Berlin School Superintendent. A one-hour session on "Mellowing" will be the presentation of Darold A Treffert, MD, Fond du Lac County Mental Health Center. The two-hour afternoon session will deal with "Child Psychology" under the direction of Dr Harvey I Kaufman, Fond du Lac County Mental Health Center. A luncheon, honoring Past State Presidents and Chapter Presidents, will be held at noon. Membership and Publication Awards will be presented at that time.

A cocktail party will precede the formal evening banquet which will feature entertainment by

the Fond du Lac Community Players and the Covenant United Methodist Church Bell Ringers. President Carol Wiesner, CMA of Black Creek, will pass the gavel to the new President, Sheila Sue Carlson of Milton, at an impressive installation ceremony conducted by Jane Dowds, CMA-AC. Rock Chapter will honor the new President with a reception following the banquet.

Sunday morning, May 17, an ecumenical church service will precede the traditional Brunch where a summary of the House of Delegates will be presented and 1981-1982 committees will be introduced. An invitation to the 1982 Annual Meeting at the Mead Inn, Wisconsin Rapids, will be issued by Wood Chapter. Following announcements and distribution of door prizes, the meeting will close and the members will go their various ways to "Light the Way with AAMA."

Inquiries are welcome and may be directed to the Annual Meeting Co-chairmen:

Mrs June Wohler
Mrs Gail Luttenberger
408 Sherman Street
Fond du Lac, Wisconsin 54935
Telephone: Home (414) 923-0462
Office (414) 921-7400 ■

State Medical Society of Wisconsin

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June 27-July 11, 1981

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PD-400-JA-0146-P-1 (1-81)

The Veterans Administration Department of Medicine and Surgery recently named Philip T White, MD as its associate deputy chief medical director. Doctor White previously served as chief-of-staff at the VA's Chicago Medial Center and also was associate chief-of-staff for education at the Wadsworth, Calif, VA Medical Center. From 1966 until 1973 Doctor White served as associate dean and chairman of the department of neurology at the Medical College of Wisconsin in Milwaukee.

Marshfield Clinic recently reelected Nelson A Moffat,* to a second term as president of the Clinic. Also reelected were MDs Cesar N Reyes,* vice-president; J Douglas Lee,* secretary; and William J Maurer,* treasurer. Joining the officers on the new executive committee are MDs Ben R Lawton,* Frederic P Westbrook,* William Dovenbarger,* Jerry M Hardacre,* and John P Milbaurer.* Doctor Moffat, a specialist in urology, joined the Clinic in 1962 and also is chairman of the State Medical Examining Board.

St Joseph's Hospital, Marshfield, has named the following MDs to head its medical staff for 1981. They are Guerdon Coombs, an endocrinologist, chief-of-staff; Raymond Hansen,* a pediatric allergist, vice-chief-of-staff; and Paul Treuhaft,* an orthopedic surgeon, has been named secretary. Two members at large also named were MDs Joseph Mazza,* a hematologist; and William Toyama,* a pediatric surgeon.

St Catherine's Hospital, Kenosha, recently named Lee H Huberty, MD,* director of medical affairs. A general radiologist, Doctor Huberty practices at St Catherine's, Burlington Memorial Hospital, and the Racine Medical Clinic. He also is a clinical instructor in the department of radiology at the Medical College of Wisconsin in Milwaukee.

Holy Cross Hospital, Merrill, has elected Thomas P Simerson, MD* as its president of the medical staff. Muhammad Y Ahmad, MD* was elected vice-president, and reelected secretary-treasurer was Walter Lewinnek, MD*. The medical staff of Holy Cross Hospital now consists of 14 active members, one provisional staff member, one honorary member, six courtesy staff members, and 31 consulting staff members.

Indianhead Medical Group, Ltd, Rice Lake, recently announced the appointment of a new administrator, Thomas A Fenger, PhD, formerly of Pocatello, Idaho. Doctor Fenger previously was a university professor of hospital and health administration at Idaho State University and also was a professor of health education and prospective medicine at the University of Minnesota School of Medicine in Duluth. He also worked for the State of Utah Health Systems Agency as a research director of health information systems. He has a doctor of philosophy degree in hospital and health administration.

Sacred Heart Rehabilitation Hospital has attained PSRO (Professional Standards Review Organization) delegated status, according to Ferdinand Leyva, administrator of the 96-bed regional physical rehabilitation facility in Milwaukee. The Foundation for Medical Care Evaluation has determined that SHRH is and has been conducting an internal, effective review process which meets the requirements of PSRO, and is therefore capable of performing its own review as a "delegated" hospital. The Foundation was established in April 1973 as a nonprofit corporation for the purpose of assuring the quality of medical care through peer review within the seven-county area of Southeastern Wisconsin. The PSRO program was enacted on October 30, 1972 as part of the 1972 Amendments to the Social Security Act. Congress passed the amendment in an effort to improve utilization controls, cut down on unnecessary services that are not consistent with proper healthcare, provide an integrated review system for the Medicare, Medicaid, and Maternal/Child Health programs, accomplishing all this through increased physician participation.

University of Wisconsin-Madison Center for Health Sciences. A new computer program developed at the University of Wisconsin may help psychiatrists make quicker and more accurate patient diagnoses, says John Greist, MD, professor of psychiatry at the UW Hospital and Clinics and Medical School. The program is based on a new diagnostic and statistical manual developed by the American Psychiatric Association. Clinicians must now diagnose consistent with the new manual to qualify patients for third party coverage, Doctor Greist adds. Doctor Greist, James Jefferson, MD, and industrial engineer Harold Erdman developed the program to help close the gap between new developments in psychiatry and what is known and practiced by clinicians. The Wisconsin researchers are hopeful that the computer will reduce many diagnostic errors, in addition to speeding up the diagnostic process. Some 80 patients have been studied with the new program. This work was supported in part by a grant from the National Institute of Mental Health. Results of the study were reported recently at the Symposium on Computer Applications in Medical Care, in Washington, DC. ■

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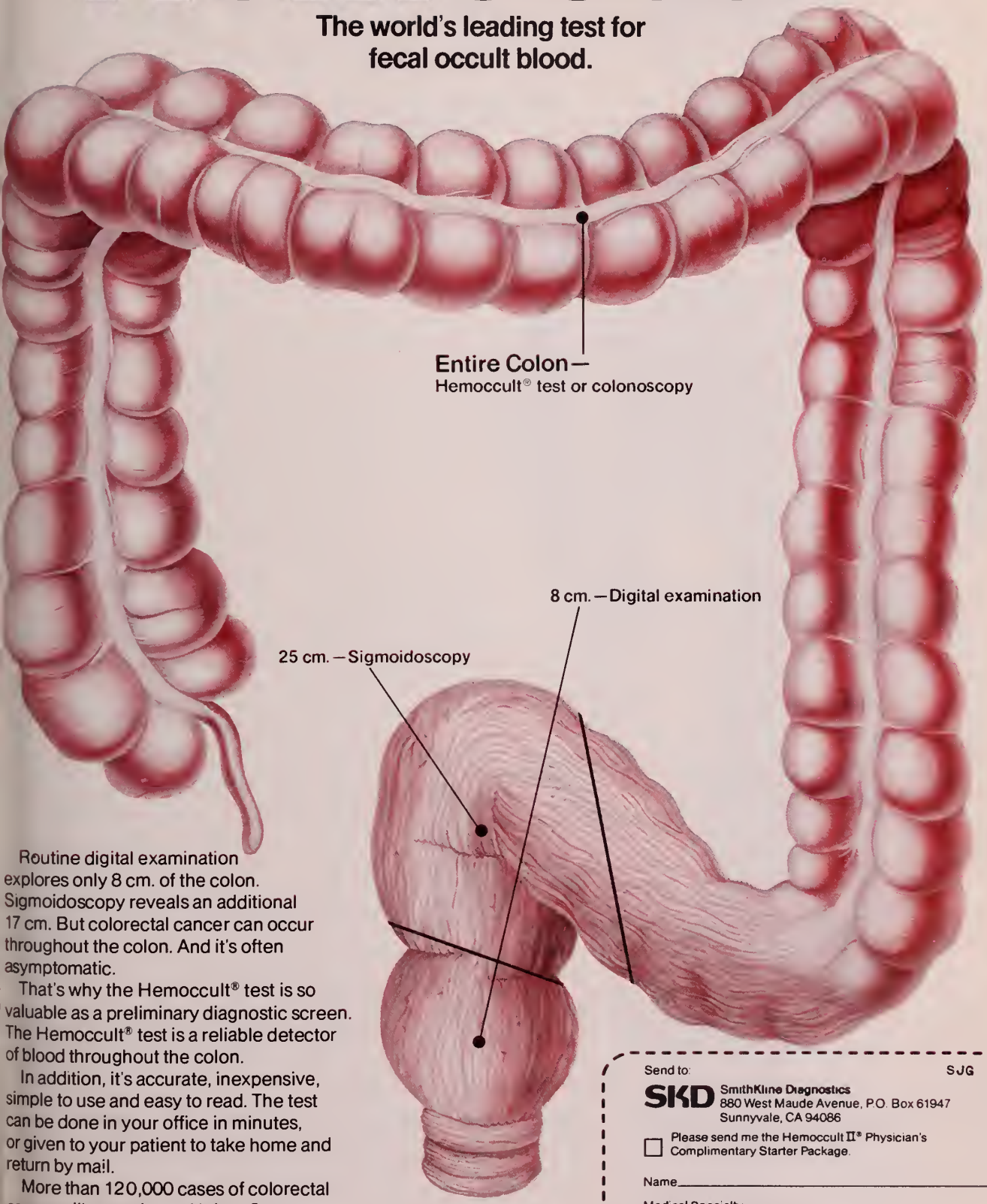

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CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated ad tion of this drug and it should be prescribed and administered with the same degree of caution appropriate to the us oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Fed trolled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this dru be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) c tantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contempla dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal deve Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their ca elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial l a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obs clinical course of patients with head injuries.

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ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory pati some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion ness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be mani a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated ad tion of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the respon patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual a for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

Wellcome

Burroughs Wellcom
Research Triangle P
North Carolina 277

Medical Yellow Pages

ADVERTISEMENTS in this section are accepted in the following categories: PHYSICIANS EXCHANGE, PRACTICES AVAILABLE, MEDICAL FACILITIES, ALLIED HEALTH SERVICES, and MISCELLANEOUS. RATES: 35¢ per word, with a minimum charge of $14.00 per ad. BOXED AD RATES: $25.00 per column inch. DISPLAY AD RATES: 15% premium on space rate, as charged in other sections of Journal. For display ad space rates consult the Wisconsin Medical Journal office. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800-362-9080.

Physicians Exchange

Emergency Medicine. Directorship and clinical positions in low volume emergency department located in the northwestern portion of Wisconsin. Excellent income with additional compensation for director's responsibilities. Paid professional liability insurance, flexible scheduling without on-call involvement. For details contact Frank Siano toll-free at 1/800/325-3982, or send credentials in complete confidence to 970 Executive Parkway, St Louis, MO 63141. 1-3/81

Board certified or Eligible primary care internist and family practitioners for full-time positions in medical school and teaching hospital affiliated community ambulatory care centers. Appointees eligible for faculty appointments. Wisconsin licensure required. Positions available July 1981. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 West Wisconsin Ave, Milwaukee, Wis 53233. Equal Opportunity Employer M/F/H. 1-4/81

Board eligible or Board certified psychiatrist to join group of 49 medical specialists. To work with another psychiatrist, psychologist, and a clinical social worker in both outpatient and hospital environment. The Department covers a broad-based psychiatric practice. Quality medicine close to University Centers. Competitive income. Contact R E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566, or telephone collect 608/328-7000. 1-3/81

Emergency Physician needed June-July 1981 to replace vacancy in five physician career oriented group at Madison, Wisconsin's largest emergency service. Great place to work and live. Send CV and will call you. John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 2tfn/81

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095
8-12/80,1-7/81

Relocation opportunities or initial practice in Fox Valley for general internists, family practitioners, and pediatricians. Support of other independent practitioners assured. Excellent schools, recreational area, as well as clinical facilities in JCAH approved hospital. PO Box 801, Neenah, Wis 54956. p11-12/80,1-4/81

Family Practice. General Clinic — Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Opportunity available in an community southwest of Eau Claire, Wisconsin. Financial assistance available to establish practice. Replacement hospital facility under construction. For details, send curriculum vitae, or call collect Recruitment Director, Adventist Health System North, 15 Salt Creek Lane, Hinsdale, Ill 60521; ph 312/920-1100. 3-4/81

Emergency Physician: Southeastern Wisconsin, begin July 1981. Flexible schedule and excellent salary are guaranteed. Send CV to: Associated E R Physicians, 1131 Sherwood Lane, Caledonia, Wis 53108; ph 414/835-4889. 3-5/81

Primary Care Physicians and ENT need for growing Wisconsin community 5 miles from Duluth. Minimum guarantee, plus assistance with housing, office space and equipment. 5,000-seat arena brings top notch professional entertainment. Also fishing, boating, etc. For details call collect or write: Nancy B Miner, Professional Relations, Hospital Affiliates, Int, Two Maryland Farms, Nashville, TN 37211. Phone: 615/377-1011. p3/81

Family Practice Physician sought for affluent small town with excellent social, retail, and educational resources. Easy access to year-round outdoor activities and to Chicago and Rockford for social and professional opportunities. For the family man with ambition for a successful practice.

Contact: Harvey Pettry, Administrator
Highland Hospital
1625 S State St
Belvidere, IL 61008
815/547-5441 3-5/81

Physicians Exchange

continued

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 23-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 2tfn/81

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Orthopedic surgeon wanted to join a primary care/specialty group of 11 physicians in northwestern Wisconsin. Attractive family/recreational area 45 minutes from Twin Cities. Minimum salary guaranteed first year. Contact Tom Halverson, Clinic Manager, St Croix Falls Clinic, Box 739, St Croix Falls, Wis 54024. Phone 715/483-3221. 8tfn/80

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

FAMILY PRACTITIONERS

Seeking a board certified/eligible family practitioner to join three family practitioners, three general internists, a pediatrician, and a general surgeon in a high quality group practice in northern Wisconsin community. Clinic building adjoins community hospital. Associate membership, then membership affiliation with a large multispecialty medical group 100 miles distant which provides the full spectrum of consulting services and laboratory and administrative support and continuing medical education opportunities. Salary and fringe benefits excellent. Practice experience desirable but not mandatory. This is an excellent opportunity to practice family medicine with skilled colleagues in a small community environment while enjoying a reasonable call schedule, freedom from business administration, and the security of ready access to consulting specialists in all fields. Send curriculum vitae and the names of persons who can be contacted for reference to:

Howard Chatterton, MD
906 College Avenue, West
Ladysmith, WI 54848 2-4/81

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Hematology/Oncology
- Family Practice
- Otolaryngology

Beautiful new building adajacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Fort Wayne, Indiana—Emergency Department Physicians. American Medical Services Association, Inc, a Kansas City based multiple hospital physician group, is seeking career oriented primary care and emergency care physicians who are:

1. Board eligible or certified
2. Show an affinity for the team concept of medical practice
3. Business oriented
4. Show professional maturity and judgment
5. Have a keen desire to succeed
6. Committed to CME

We are successful because we offer the unique package of salary and benefits in the healthcare industry. All of our physicians participate in the ownership of the company. If you feel qualified we are interested in you. Contact: Michael P Colucci, Vice-President of Marketing and Recruitment, American Medical Services Association, Inc, 4400 Broadway—Suite 306, Kansas City, Missouri 64111, 816/931-3040. 2-4/81

Locum Tenens work wanted. The more you know about choices, the easier it is to choose. That's why CompHealth, the oldest, largest locum tenens organization in the United States, can help make choices easier for you. Any specialty can be covered including FP, IM, Rad, Anes, and OB/GYN. With a large selection of reliable, qualified physicians to choose from, CompHealth provides physicians, hospitals, clinics and communities with dependable locum tenens coverage, allowing you to keep your practice covered without inconvenience or concern. Turn a difficult decision into an easy choice. Contact CompHealth, 175 West 200 South, Suite 2003, Salt Lake City, UT 84101; ph 801/532-1200. 3-5/81

Family Practice. Wanted a family practitioner to locate in new clinic building in Poynette, Wis. Located 30 miles from Madison, Wis. Poynette is a village of approximately 1000 with a service area of 7000 persons. Salary guaranteed. Contact John Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 10tfn/80

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN

MEDICAL PROFESSIONAL PLACEMENTS

5222 Painted Post Drive
Madison, Wisconsin 53716
(608) 222-2927

Licensed Employment Agency 9tfn/79

Wanted. Board certified or eligible oncologist to practice in conjunction with an 8-member medical department in a 22-member multispecialty group. Present sub-specialties: gastroenterology and cardiology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Pediatrician: Join an 18 physician multispecialty clinic in Appleton, Wisconsin. Have departments in Pediatrics, Surgery, Family Practice, Internal Medicine and OB/GYN. Need another pediatrician. Excellent hospitals, guarantee and incentive compensation. Complete benefit package. Medium size community with excellent educational, cultural, recreational, and shopping opportunities. Contact Art Schuetze, Medical Arts Clinics, SC, 401 North Oneida St, Appleton, Wis 54911. Telephone 414/739-0171. 1-3/81

The Nicolet Clinic, SC, a young progressive 33 physician multispecialty group, has superb opportunities available for the practice of:

- Family Practice
- Thoracic Surgery

Ideal family oriented community in metropolitan area with excellent schools, economy, culture, and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued medical education. Contact in confidence Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Phone: 414/727-4244. 3-6/81

Family Practitioner. An excellent family practice setting is available in Green Bay, Wis. Individualized practices, and coverage reciprocity. New 165-bed family practice hospital under construction. Write: Physicians in Family Practice, 120 Siegler St, Green Bay, Wis 54303. Tel: 414/497-0707. p2-3/81

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multi-specialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Wanted: Family or General practitioner who does obstetrics to join well-established medical group. Complete clinic facilities and full hospital privileges. Liberal educational and vacation time. Guaranteed salary and opportunity for early partnership. Contact R E Jensen, MD, Rose-Jensen-Sanan, 621 E Walnut St, Green Bay, Wis 54301. Phone: 414/437-4366. 2-4/81

Roth Young Personnel of Milwaukee
Health Care Placement Specialists

We provide a complete health care service from coast to coast for Physicians, Nurse Executives, CNS, Therapists, Technologists, etc. Through our interchange system we have available openings in the right location and setting for you! Call collect or send CV to:

Chuck Manning
Roth Young Personnel
PO Box 13527
Milwaukee, Wisconsin 53213
414/474-2280 3tfn/81*

Physical Medicine and Rehabilitation Residency. First year and advanced residency positions are now available at the University of Wisconsin Hospital and Clinics Rehabilitation Center and affiliated institutions. This newly approved program provides opportunities to participate in all aspects of the specialty in a new and comprehensive Rehabilitation Center. Patients with spinal cord injury, brain injury, stroke, chronic pain, pulmonary disorders, amputations, etc are cared for in this program. The center is well-equipped and diversified to meet the special needs of patients for training and special devices. Research and special study programs are available as part of the residency program. Stipends depend upon qualifications, but begin at $16,575 per annum. Telephone or write to: Richard F Harvey, MD, Director, Department of Rehabilitation Medicine, University of Wisconsin Hospital and Clinics, Rehabilitation Center, E3/350 Clinical Science Center, 600 Highland Ave, Madison, Wis 53792. Phone: 608/263-8632. An Equal Opportunity and Affirmative Action Employer. 3/81

General Surgeon, July 1981, to join the Wilkinson Clinic, SC, a multispecialty group of 16 physicians located in lake country between Milwaukee/Madison. Excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: David O Ulery, MD, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066. 414/567-4433. 2tfn/81

The Fond du Lac Clinic, SC, a multispecialty group of 26 physicians has an opportunity available for a fourth pediatrician. Negotiable salary with full benefits and full partnership available after one year. Contact Kirk A Veit, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, Wis 54935. p2-4/81

FAMILY PRACTITIONERS

Seeking a board certified/eligible family practitioner to join family practitioner and general internist in a high quality growing practice in northcentral rural Wisconsin. Modern clinic building adjoined to community hospital. Call shared with two other physicians in a nearby community. Associate membership, then membership affiliation with a large multispecialty medical group 60 miles distant offering the full spectrum of consulting services and providing laboratory and administrative support and continuing medical education opportunities. Salary and fringe benefits excellent. Practice experience desirable but not mandatory. This is an excellent opportunity to exercise your talents in adult medicine, pediatrics and OB-GYN in a small community environment practicing with skilled colleagues while enjoying a reasonable call schedule, freedom from business administration, and the security of ready access to consulting specialists in all fields. Send curriculum vitae and the names of persons who can be contacted for reference to:

Frederic Wesbrook, MD
Marshfield Clinic
1000 North Oak
Marshfield, WI 54449 2-4/81

Physicians Exchange

continued

Practice of General Practitioner available in Whitewater, Wisconsin. Older physician who must retire for health reasons. Can take over office with reasonable appraisal of equipment. Three GPs and one osteopath in community with UW campus and small industries. Convenient between Milwaukee and Madison. Hospital 9 miles away in Fort Atkinson. College Health Center may desire part-time assistance. Immediate responses needed. Phone 414/473-2121, or 414/473-5171. *2-3/81

General Surgeon and Orthopedic Surgeon. Both needed for 7-man multispecialty group in town of 10,000. Located 30 miles southwest of Milwaukee. Our facility is immediately adjacent to a 140-bed hospital. Position open immediately. Please contact Wayne Hansen, Burlinton Medical Center Ltd, 190 Gardner Ave, Burlington, Wis 53105. Ph 414/763-9121. p3-5/81

Family Physician. Four-man family practice group seeking fifth to assume established practice. Northern Wisconsin community of 8,000 with primary service area of 50,000. Excellent outdoor recreation opportunities. 80-bed hospital with full-time emergency room coverage. Competitive salary and fringes. Contact: Marsh Clinic, SC, 610 W Green Bay St, Shawano, Wis 54166. Ph 715/526-3137 p3-5/81

Medical Facilities

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik (414) 921-6800. 5tfn/78

FOR RENT office space Greater Milwaukee area. 750-1500 sq ft in prestigious 3-year-old medical building located on Northridge Lakes (7400 West Brown Deer Road) only minutes from Northridge. Opportunity for medical group, specialist, or satellite office. Will remodel to suit. Please call area code 414/354-1160. 12tfn/80

Ritter ENT Unit. Includes motorized chair, service unit with air and suction and cautery and air pump. Also sterilizer with cabinet available. Good condition. Reasonable. PO Box 325, Stevens Point, Wis 54481. Phone: 715/341-2020. 2tfn/81

CONSULTANT FOR FLORIDA REAL ESTATE

A retired member of the State Medical Society of Wisconsin

HOWARD V. MORTER, MD

Licensed Broker/Salesman

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NORTH PALM BEACH, FL 33408
305/622-7006

REALTOR-Associate, Duane C. Heiser Realty Co.

For Sale: Zeiss Photomicroscope with circular rotating and centering mechanical stage, automatic exposure device and full power pack. Several objective and ocular lenses. Excellent condition. Regularly maintained by manufacturer's representative. Contact Mr. Bernard Goldstein, 606 West Wisconsin Ave, Milwaukee, Wis 53203. Phone: 414/271-1400. g10tfn/80

Real Estate

Elkhart Lake—2 bedroom rental condo on beautiful Elkhart Lake, furnished, 2½ baths, tennis, golf, 2 miles from Road America. Available May-Oct, day, week, month. $350/week. D Opel, MD, 1330 N 5th St, Sheboygan, Wis 53081; ph 414/458-4522. p3-5/81

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BUSINESS SERVICES & EQUIPMENT SHOW

April 21-22, 1981: Dane County Exposition Center, The Forum, Madison

Free admission; free parking

Special value to clinic managers in keeping up with changes in business products and systems. Computer resources, records management, telephone equipment, sound systems, typewriters, copiers. Free seminar entitled *"The Office of the '80s: Designing for productivity and Human Factors,"* as well as films aimed at enhancing office productivity. Info: Gene Anderson, American Breeders Service, DeForest, Wis. Ph: 608/846-3721. 3/81

Meetings CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 35¢ per word, with a minimum charge of $14.00 per listing. BOXED LISTINGS (same type as used in regular listings): $25.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is first of the month preceding the month of poblication; e.g., copy for the August issue is due by July 1. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1980 through Aug 31, 1981.

APRIL 9-10, 1981: *7th National Conference on Case Resolution of Complex Industrially Injured,* Pioneer Inn, Oshkosh, Wis. Sponsored by Industrial Injury Clinic, University of Wisconsin-Extension, Continuing Medical Education, in cooperation with Theda Clark Regional Medical Center. AMA Category I, Continuing Legal Education credits, Commission on Rehabilitation Counselor Certification, University of Wisconsin Continuing Education units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

APRIL 9-11, 1981: *Coronary Heart Disease 1981,* presented by St Luke's Hospital and St. Luke's Hospital Foundation, Inc, at Hyatt Regency Milwaukee, in Milwaukee. Meets criteria for 16 hours in Category I of PRA-AMA; also acceptable for 16 prescribed credit hours by AAFP. Fee: $250, payable to: St Luke's Hospital, and sent to: Mrs Dorothy Black, Public Relations Dept, St Luke's Hospital, 2900 W Oklahoma Ave, Milwaukee, WI 53215.

APRIL 24, 1981: *Perspectives in Diabetes Mellitus—1981,* Madison. Approved 7 credit hours AMA and LCCME Category I, Family Practice credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

APRIL 22-24, 1981: *The Geriatric Patient,* Inn on the Park, Madison. Sponsored by the Extension Services in Pharmacy, in cooperation with the School of Pharmacy, University of Wisconsin, Madison. The conference will explore economic, physiological, psychological and social aspects of aging along with numerous therapeutic issues. Extension Services in Pharmacy has accredited the conference for 14 continuing education hours (1.4 CEU's). In addition, the conference is acceptable for 14 credit hours in Category I of AMA-PRA. Info: Alan L Hanson, PhD, Extension Services in Pharmacy, School of Pharmacy, 425 N Charter St, Madison, Wis 53706, or call 608/262-3130.

APRIL 28, 1981, Green Bay; APRIL 29, Wausau; APRIL 30, Eau Claire: *Suicide Assessment and Intervention.* Sponsored by Allied Health Program Unit, University of Wisconsin-Extension; and Continuing Education in Mental Health, University of Wisconsin-Extension. Approved 6 hours of University of Wisconsin Continuing Education credit. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

MAY 1, 1981: Second Annual Professional Institute, *Guilt,* sponsored by the Department of Psychiatry, Mount Sinai Medical Center, at Sheraton Mayfair Hotel, 2303 North Mayfair Rd, Milwaukee, Wis. Approved 6 credit hours of Category I of AMA-PRA. Info: Bella H Selan, MS, Mount Sinai Medical Center, Outpatient Psychiatry Clinic, 950 North 12th St, Milwaukee, Wis 53233.

MAY 1-2, 1981: *Trends in Radiologic Technology—1981,* Wisconsin Center, Madison, Wis. Sponsored by Allied Health Program Unit, University of Wisconsin-Extension; and Department of Radiology, School of Medicine, University of Wisconsin, Madison. ECE points applied for from ASRT; University of Wisconsin Continuing Education Units.Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

Thirteenth Annual
Southeastern Wisconsin Cancer Conference
OVARIAN CARCINOMA

Saturday, May 9, 1981
Pfister Hotel, Milwaukee

8:00 am - 12:30 pm

Faculty: Rocco Latorraca, MD, Chairman, Planning Committee; Robert E Scully, MD, Professor Pathology, Massachusetts General Hospital, Harvard Medical School; Hervy E Averette, MD, Professor and Director, Division of Gynecologic Oncology, University of Miami; Raymond S Bush, MD, Director The Ontario Cancer Institute; Robert Young, MD, Chief, Medical Branch, National Cancer Institutes.

No registration fee. Preregistration reservations should be mailed to: American Cancer Society, 6401 West Capitol Drive, Milwaukee, Wis 53216.

Through cosponsorship by the Medical College of Wisconsin, three hours of Category I credit of AMA-PRA and three hours of elective credit by the American Academy of Family Physicians have been approved.

WISCONSIN continued

MAY 4-6, 1981: *Intravenous-Arteriography.* University of Wisconsin-Madison, Memorial Union, Madison. Approved 16 credit hours Category I and 16 hours American College of Radiology. Fee: $395. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706. Phone: 608/263-2856.

MAY 6-8, 1981: *4th Annual Cardiac Rehabilitation Symposium,* Red Carpet Inn, Milwaukee, Wis. Sponsored by University of Wisconsin-Extension, Continuing Medical Education; Mt Sinai Medical Center, Milwaukee, American Heart Association. Approved 21 hours AMA Category 1, 2.1 University of Wisconsin continuing education units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

MAY 7-8, 1981: Wisconsin Health Science Library Association Meeting, Milwaukee. Contact Bess Stein, Todd Wehr Library, Medical College of Wisconsin, Box 26509, Milwaukee, Wis 53226 (phone: 414/257-8323).

MAY 8, 1981: Second Annual Professional Institute, *Obesity,* sponsored by the Department of Psychiatry, Mount Sinai Medical Center, at Sheraton Mayfair Hotel, 2303 North Mayfair Rd, Milwaukee, Wis. Approved 6 credit hours of Category I of AMA-PRA. Info: Bella H Selan, MS, Mount Sinai Medical Center, Outpatient Psychiatry Clinic, 950 North 12th St, Milwaukee, Wis 53233.

MAY 8-9, 1981: Annual Scientific Program of the Wisconsin Chapter of the American Academy of Pediatrics, Pioneer Inn, Oshkosh. Info: Frank Stiles, MD, Program Chairman, The Monroe Clinic, Monroe, Wis 53566.

MAY 9, 1981: Thirteenth Annual Southeastern Wisconsin Cancer Conference, Pfister Hotel, Milwaukee. Approved 3 credit hours of Category I of AMA-PRA and AAFP. Info: American Cancer Society, 6401 W Capitol Dr, Milwaukee, Wis 53216. (See further details elsewhere in this section.)

MAY 15, 1981: Second Annual Professional Institute, *Late Life Care,* sponsored by the Department of Psychiatry, Mount Sinai Medical Center, at Sheraton Mayfair Hotel, 2303 North Mayfair Rd, Milwaukee, Wis. Approved 6 credit hours of Category I of AMA-PRA. Info: Bella H Selan, MS, Mount Sinai Medical Center, Outpatient Psychiatry Clinic, 950 North 12th St, Milwaukee, Wis 53233.

MAY 22-28, 1981: *Holistic Health: The Family Practice of the 80's,* sponsored by the American Holistic Medical Institute, at the University of Wisconsin-LaCrosse. (See further details in ad elsewhere in this section.)

JUNE 4-6, 1981: *Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias,* The Performing Arts, Milwaukee. Approved 18 credit hours of Category I of PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

JUNE 11-12, 1981: *Neurological Intensive Care Symposium,* Wisconsin Center, Madison, Wis. Sponsored by Continuing Medical Education, University of Wisconsin-Extension; and Division of Neurological Surgery, School of Medicine, University of Wisconsin, Madison. Approved 17 hours AMA Category I; 1.7 continuing education units, University of Wisconsin-Extension. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

AMERICAN HOLISTIC MEDICAL INSTITUTE

8th Scientific Meeting

HOLISTIC HEALTH: THE FAMILY PRACTICE OF THE 80's

UNIVERSITY OF WISCONSIN-LA CROSSE

MAY 22 — 28, 1981

Over 60 Workshops and Lectures. Choose a track of general Holism or concentrate in one field: Nutrition, Physical Exercise, Neuromuscular Integration, Osteopathic Manipulative Treatment, Spiritual Attunement, Environmental Medicine, Clinical Ecology, Biomolecular Medicine, Holistic Psychology, Self-Regulation, Biofeedback, Holistic Nursing, Holistic Dentistry. **Featuring Nutrition Debate of the century!**

THE INFLATION BEATER! - less than $7/cr. hr. for M.D.'s
- less than $6/cr. hr. for Health Professionals - Room and meals for less than $30/day.

Distinguished Faculty of over 50 Presenters including:

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- Irvin Korr
- John Olwin
- Kenneth Pelletier
- Theron Randolph
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- Bernard Siegel
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As an organization accredited by the Liaison Committee on Continuing Medical Education to provide continuing medical education, the American Holistic Medical Association certifies that this continuing medical offering meets the criteria for 40 hours of LCCME Category I credits provided it is used and completed as designed.

AHMI

% Division of University Outreach, UW-La Crosse, La Crosse, WI 54601

JUNE 25-27, 1981: Annual Meeting of the Wisconsin Academy of Family Physicians, Hyatt Regency Hotel, Milwaukee. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

JUNE 27-JUNE 11, 1981: *Scandinavian Holiday,* sponsored by the State Medical Society of Wisconsin. Cost: $1,998, round trip Milwaukee or Madison to New York to Copenhagen with return from Stockholm via Northwest Orient Airlines. Reserve space for $150 and final payment due on April 15, 1981. Info: Dittmann Tours, Inc, PO Box 199, Northfield, MN 55057, or contact Lee Johnson, SMS, toll-free 1-800-362-9080.

UPPER MIDWEST

MAY 3-6, 1981 (Nebraska): Annual Meeting, Nebraska Medical Association, at Lincoln. Info: K E Neff, Exec Dir, 1512 First National Bank Bldg, Lincoln, NE 68508.

MAY 20-22, 1981 (Minnesota): Annual Meeting, Minnesota State Medical Association, at Minneapolis. Info: H W Brunn, Exec Vice-pres, 2221 University Ave SE, Suite 400, Minneapolis, MN 55414.

MAY 21-22, 1981 (Illinois): *Medical Determinations in Workers' Compensation,* sponsored by the American Society of Law & Medicine at Ambassador West Hotel, Chicago, Ill. Info: A Edward Doudera, JD, Executive Director, American Society of Law & Medicine, 520 Commonwealth Ave, Boston, MA 02215.

1981 HUMANITIES SEMINARS FOR PHYSICIANS, NURSES, AND OTHER HEALTHCARE PRACTITIONERS

In the summer of 1981 the National Endowment for the Humanities will sponsor eight seminars for physicians, nurses, and other healthcare professionals.

The program brings them together for a month of full-time study in seminars directed by distinguished philosophers, medical teachers, social scientists, historians, and other scholars at selected colleges and universities throughout the country.

Its purpose is to advance public understanding and use of the humanities by giving professional leaders the opportunity to stand back from their work and explore a wide range of issues of national concern under the direction of scholars in the humanities.

Three seminars are open only to physicians, nurses, public health officials, hospital administrators, and other healthcare practitioners. In addition, five Interprofessional Seminars are offered for healthcare practitioners and members of other professions.

Topics include ethicolegal issues raised by new developments in genetic science, the political dimension of healthcare policy, the healer and society in Western culture; and, among Interprofessional Seminar topics, morality and international relations, taste and US popular culture, conflicts between individual values and professional responsibilities, competing rights claims in contemporary society, and Caribbean societies and relations with the US.

From 12 to 15 persons attend each seminar tuition-free, receiving a stipend of $1,200 plus reimbursement for travel. The application deadline is April 13, 1981.

For applications and further information write: Professions Program, Division of Fellowships & Seminars, MS-101, National Endowment for the Humanities, Washington, DC 20506.

OTHERS

APRIL 21-23, 1981 (Washington, DC): Technical assessment forum to address the economic, ethical, legal, and social issues related to *coronary artery bypass surgery,* at the Sheraton Washington Hotel, Washington, DC. Conducted by the National Center for Health Care Technology (Center) in collaboration with the National Heart, Lung, and Blood Institute. Open to the public, no registration fee. Health professionals and interested private citizens encouraged to attend. Technical info: Michael Eliastam, MD, Special Assistant to the Director, National Center for Health Care Technology, Parklawn Building, Room 17A-29, 5600 Fishers Lane, Rockville, MD 20857; phone 301/443-4097.

JULY 29—AUG 8, 1981 (Caribbean): Ten-day cruise, departs Ft Lauderdale on July 29 and stops at St Maarten, Antigua, Barbados, Martinique, and St Thomas. Approved 23 credit hours of Category I of AMA-PRA. Info: International Conferences, Suite C, 189 Lodge Ave, Huntington Station, NY 11746. Phone: 516/549-0869. (See ad elsewhere in this section.)

AUG 22-SEPT 5, 1981 (Mediterranean): Fourteen-day cruise, departs Venice, Italy, and visiting Egypt, Israel, Turkey, and Yugoslavia. Approved 23 credit hours of Category I of AMA-PRA. Info: International Conferences, Suite C, 189 Lodge Ave, Huntington Station, NY 11746. Phone: 516/549-0869. (See ad elsewhere in this section.)

AMA—1981

JUNE 7-11: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

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News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

GOVERNOR CALLS FOR DEREGULATION OF LICENSING BOARDS. Governor Dreyfus has announced plans to take examining powers away from the state's 17 occupational licensing boards, including the Medical Examining Board, and give them to the Dept of Regulation and Licensing. The boards would be reestablished as disciplinary boards that would also serve in an advisory capacity to the Department in developing examining and licensing rules. In making his announcement, Dreyfus said that instead of guarding the public by policing their ranks, many of the boards tend to protect their fellow licensees. He also left open the possibility that the health occupations might be exempted from the proposal. The SMS Council, at its January 24 meeting, expressed opposition to the proposal stating that it would not allow the board to initiate, on its own, rules for the conduct of physicians in Wisconsin.

NEW STATE LAW REQUIRES REPORTING OF LEAD INTOXICATION CASES. On April 28, 1980, Governor Dreyfus signed the State mini-budget for 1980. Included in this mini-budget is legislation supporting lead poisoning prevention activities in Wisconsin. As a result, Wisconsin now has a law (effective May 1, 1980) which will help to insure that people tested for and found with lead intoxication will have the source of lead identified and reduced in their environment. One section of the law deals with the reporting of all cases of lead intoxication. It states that lead intoxication cases discovered by physicians, nurses, hospital administrators, laboratory directors, or public health officers now must be reported to the Department of Health and Social Services (DHSS) or the local public health officer. Wisconsin physicians were recently mailed a copy of the form which will be used for reporting lead intoxication cases. This law is particularly for the benefit of children ages one to six years.

Within the DHSS, the Division of Health, Bureau of Prevention, has a childhood lead poisoning prevention project. Physicians are encouraged to contact that office for further information regarding lead intoxication or this new legislation relating to its prevention in Wisconsin. The Society also encourages physicians to make use of the consultation services offered by the Bureau of Prevention. In addition, a copy of the CDC booklet, ***Preventing Lead Poisoning in Your Children***, is available upon request to the Bureau. The number of the Wisconsin Childhood Lead Poisoning Prevention Project is 608/266-5647 or 266-8403.

APPOINTMENTS ANNOUNCED FOR RISK SHARING PLAN GOVERNING BOARD. State Insurance Commissioner Susan Mitchell has named the governing board for the new Health Insurance Risk Sharing Plan established by the Legislature last session. The appointees are: Dick Byron, Employers Insurance of Wausau; Ken Clark, Health Policy Council representative; Michael Falconer, Executive Director, Governor's Committee for People with Disabilities; Dianne Greenley, Center for Public Representation; Jim Lockerbie, Wisconsin Physicians Service; Carol McKy, Governor's Committee for Women's Initiatives; Sam Miller, Wisconsin Employers Insurance Co; Andrew Rajec, Blue Cross & Blue Shield United of Wisconsin. Mary Michal Bach will represent the commissioner's office on the board.

WHCLIP'S TAX-EXEMPT STATUS QUESTIONED. The Wisconsin Health Care Liability Insurance Plan (WHCLIP) recently received an adverse ruling from the Internal Revenue Service on the validity of its tax-exempt status. WHCLIP currently provides medical liability insurance to approximately 55% of the state's physicians.

WHCLIP has contended that as a nonprofit agent of the state, it is exempt from paying state and federal income tax. While the State Attorney General and even the regional IRS office have expressed agreement with this position, the Washington, DC office of the IRS has declared that WHCLIP is a taxable entity and at this writing was preparing an assessment to be submitted to WHCLIP in early 1981. The potential tax liability is estimated at $11 million. Upon receipt of the tax assessment, WHCLIP intends to file an appeal and challenge the IRS decision.

The Independent Insurance Agents of Wisconsin allege that the tax-exempt status gives WHCLIP an unfair advantage over commercial carriers and asked that the WHCLIP Board not appeal the IRS decision. Fred Kriss, MD, Madison, (State Medical Society representative on the WHCLIP Board of Governors) told the Board in December that the major advantage of WHCLIP over commercial carriers is WHCLIP's policy of not denying or cancelling coverage of any physician because of that physician's specialty or past experience. Doctor Kriss reminded the Board that it was the commercial market's refusal to provide coverage to high risk and newly licensed physicians that prompted the legislative creation of WHCLIP in 1975.

continued on other pages of this issue

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APRIL 1981

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AUG - 3 1981

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Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies The physician should periodically reassess the usefulness of the drug for the individual patient
Contraindicated: Known hypersensitivity to the drug Children under 6 months of age Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy, gradually taper dosage Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy
Dosage: Individualize for maximum beneficial effect. *Adults* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b i d to q.i.d., alcoholism, 10 mg t.i.d or q.i d in first 24 hours, then 5 mg t i d or q i d as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t i d or q i.d , adjunctively in convulsive disorders, 2 to 10 mg b i d to q i.d. *Geriatric or debilitated patients* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated (See Precautions) *Children*. 1 to 2½ mg t.i.d or q i.d initially, increasing as needed and tolerated (not for use under 6 months)
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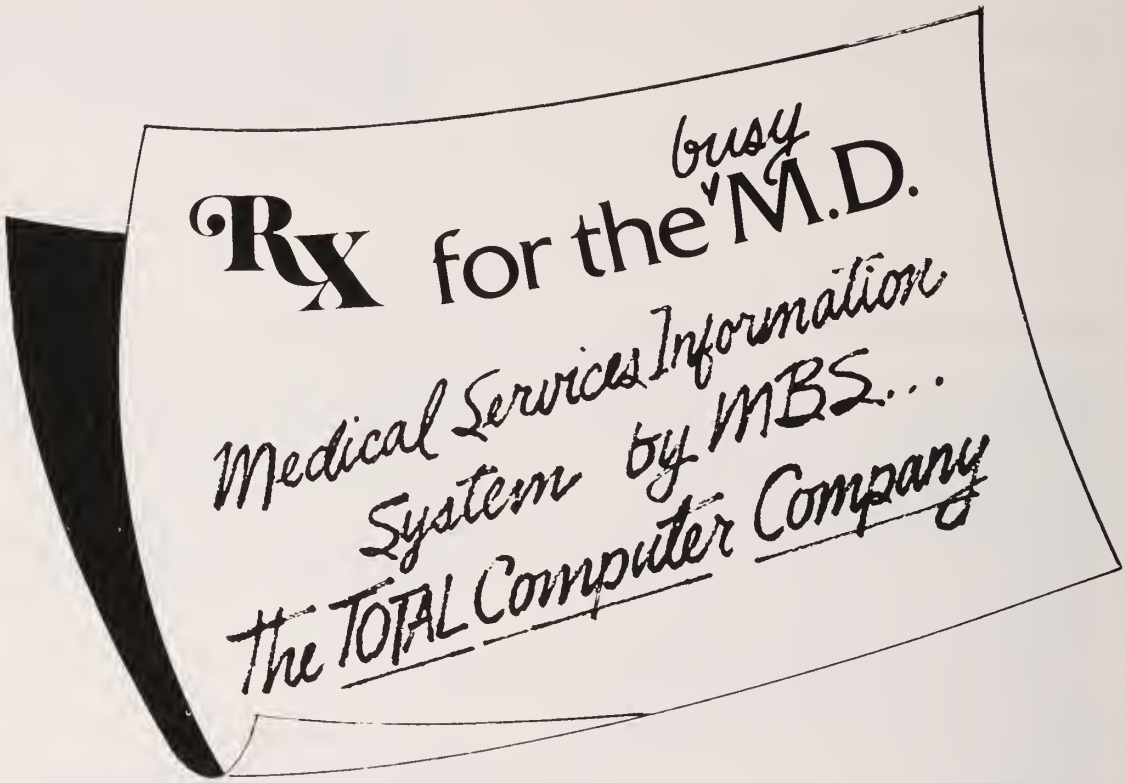
CORRECTION: In the March issue there is an error in the article, "Probable carbon dioxide embolism during laparoscopy; case report," by Nichols, Tompkins, and Henderson. On page 28, second column, last paragraph, third and fourth lines state erroneously that in the management of CO_2 embolism the patient should be hyperventilated with 100% carbon dioxide. Stated correctly, the patient should be hyperventilated with 100% oxygen (O_2). Under no circumstances should any patient or subject be ventilated with 100% carbon dioxide.—*Bonnie M Tompkins, MD*
Wisconsin Medical Journal



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Editorials

WAYNE J BOULANGER, MD, *Editorial Director*

In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Chronic mental illness

THIS ENTIRE ISSUE of the *Wisconsin Medical Journal* is devoted to the subject of chronic mental illness. Dr Charles Landis, who was chairman of the Mental Health Committee in 1980, graciously agreed to be the guest editor for this special issue.

Doctor Landis selected the panel of authors and he is to be commended for assembling the material for this issue in the short time allotted him.

Scarcely a day goes by that our newspapers don't carry an article on some phase of mental illness. Here are examples of some headlines: "Drug, alcohol abuse elderly problem now"; "Study calls for moving mentally retarded from nursing homes"; "Revised funding for chronically ill"; "A woman on the path—an overdose—a death"; "Services for mentally ill plenty—costly in county"; "Mental patient rights are extended further by new court decision" (from the *Wall Street Journal*); "New commitment law may enable more people to get treatment"; "Community program lets mentally ill cope with life"; "Opinions divided on blame" (relative to the closing of a department store on the Capitol Square in Madison where the "Mentally ill downtown are disrupting stores"); "Justice for retarded lacking".

Most of the articles in this issue pertain particularly to problems of the chronically mentally ill. It is the hope of the Mental Health Committee and the *Wisconsin Medical Journal* that this issue will have some influence on the outcome of legislation in the 1981 session.—VSF

Access without consent

THE GOVERNOR of Wisconsin has spoken with eloquence about the need to rid our statute books of costly, abusive, or needless legislation. One recent law cries for such action. It was called the "right of access to medical records" bill.

Doctors have long recognized the rights of patients to confidentiality of their medical records as well as the patient's right to examine those records. The Legislature in 1980 simply put on the books what doctors had been doing for decades.

However, the Legislature went gravely awry in making one particular exception to the confidentiality statutes. It said that any state or federal agency in the course of any legally authorized function may require a physician to release any and all patient care records it demands without the patient's information or consent. A private patient can deny the government this access only if he or she annually submits to the Department of Health and Social Services an access denial form prepared by the Department.

In giving itself access to private patient records without informed consent, the government has probably violated the constitutional rights of some 5 million citizens in Wisconsin. Even more absurd is the means by which a patient is given the right to deny access.

Please note: the doctor is not hurt by this law, only the patient. What of the state employee whose medical records are now open to the employer for the asking? What about John Q Citizen whose private patient records might be of interest to any curious project of a state or federal agency? Patients and citizens should be outraged.

Shame on INS

ABOUT 1970 THE government of the United States eased immigration laws, especially for Philippine physicians. This was done to relieve what was perceived as a shortage of physicians. The reaction was predictable. Philippine physicians came to America in large numbers. Most were admitted on temporary visas. The Immigration and Naturalization Service (INS) promised in writing that "soon" they would be given a permanent visa number which would permit them to seek citizenship. At least 20 to 25 of these Philippine physicians live and practice in Wisconsin.

Today, ten years later, they are still waiting for this magic number.

We urged them to come here. We have had the benefit of their services, their income and other tax payments, their skills, their cultural contributions. They teach our medical students. They treat our sick. They save our lives. They belong to our medical societies and the AMA.

Yet they can't vote. They live in limbo. They are severely restricted in their travel. If they go outside our borders, they risk not getting back in. There is strong evidence that they can buy relief through payoff to the "right places." Even Wisconsin congressmen seem to confirm that these doctors are victims of one of the worst bureaucracies in America, the INS.

They are invited hostages in this "land of the free!" Shame on INS.

Wellspring!

SEVERAL YEARS ago in the flurry to comply with government pressures toward better documentation of peer review, the State Medical Society of Wisconsin applied the major impetus in development of WHCRI—Wisconsin Health Care Review, Incorporated. Most of us believed it would evolve into what WisPRO has become. This was not to be the case, however, because of organizational technicalities too complex to recount here. In any event, instead of disbanding when WisPRO became the PSRO for the entire state (except for the seven-county area of southeastern Wisconsin) WHCRI took off in other directions, and now provides services which have nothing to do with peer review or any other State Medical Society interests.

Current WHCRI programs include: Provision of administrative services to the State's EPSDT (early, periodic, screening, diagnosis and treatment) program; providing nutrition education and health screening to children under the Federal Government's Women's Infants and Children (WIC) program; and evaluating the effectiveness of the Wisconsin Quality Assurance Project in assuring the reasonableness of cost of nursing home care. In the planning stage is a resource center for alternative health delivery systems. A small hospital assistance planning and evaluation program also is in the wings. Not really Medical Society concerns!

Four members of the State Medical Society remain on the board of directors, however, and in the minds of many the term, WHCRI, still suggests strong State Medical Society influence. Perhaps it is just as well, then, that the name has been changed. Cameron Brown, the executive director of WHCRI, in a status report to the Council, announced that a consulting firm whose business includes conjuring up names for organizations had arrived at "WELLSPRING" as its first choice. And happily, since we are all so cost-conscious these days, they were able to provide this service for only $2,500!

Mr Brown also made other statements which some of us found rather thought-provoking. For instance this organization, which most of us felt would simply wither and die, now employs 30 full-time people, and has a budget of $1.1 million, and getting bigger, so that a $2 million budget is on the horizon.

Discussion of the merits of WELLSPRING is not appropriate here. The question is whether the State Medical Society should retain any connection at all with an organization whose development has taken it so far from its original goals, especially one which seems to be looking for more and more ways to expand and spend grant money which ultimately comes out of taxpayers' pockets.—WJB

Still a way to go—Baby

MAYBE IT IS just the provincial attitude of northeastern Wisconsin, but implementing the women's liberation program in this parochial zone still needs a bit of work.

Those of us who occasionally deal with high school students on Career Day often find the subtle evidences of the status quo and the perpetuation of the "male chauvinist" attitudes. Most of the people being encouraged to go into medicine are boys. Those being encouraged to go into medical technology, nursing, or x-ray technology are girls. These are the attitudes being inculcated into the students by their school teachers.

If you talk to the girls, they are almost never advised to become stock brokers, accountants, even attorneys or engineers. They are directed into nursing and other hospital related paramedical fields by faculty members who apparently have never heard of the other options. Many of the young ladies are not aware of the job opportunities in sales particularly of insurance, securities, banking services, or numerous other business related fields. Do the faculty members who are advisors honestly feel that girls are better suited to be nurses or medical technologists?

Looking back, everybody remembers that the smartest students in any class were always girls. What happens to these young ladies? Do ill-advised faculty members force them into the less demanding and lower paying jobs?

You come along way baby, but you still have a long way to go.—RAM

After the fact

THE HEALTH PLANNING COUNCIL (HPC) is one of many federal agencies. Its function is to review facility proposals presented by healthcare providers.

The February HPC *Profiles* lists a facility review calendar. This indicates the applicants and facility proposals. In January 1981, they approved $644, 024 for the medical clinic addition to a relatively small town community hospital.

The approval of this facility is not questioned, except that the building was erected several years ago and has been in use ever since. The decision of the HPC seems to be somewhat after the fact. Is this typical of HPC action?

Perhaps the HPC along with a number of other federal regulatory agencies may find themselves in the near future without, or at least with drastically diminished, funding. It is not anticipated that this will result in widespread anguish.—VSF ■

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Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

In Medicaid reimbursement, we ask only for equity and fairness

IN MARCH THE Executive Committee of the State Medical Society Council sent the following letter to Governor Lee S Dreyfus:

***

The State Medical Society and its member physicians have a clear and continuing record of cooperation with you, your administration, and the Department of Health and Social Services in efforts to contain costs, live within budgets, reduce government regulation, and yet assure a socially responsible system of health care in this state.

Last year when you called for a 4.4% spending cut in Medicaid, the physicians of Wisconsin, encouraged by the State Medical Society, agreed voluntarily to abide by your request even though they had a binding contract with the state for reimbursement at a higher level.

Some other providers did not cooperate. Instead, they denounced your decision and threatened legal action. In the end no reductions were applied to their Medicaid reimbursement.

Just a few weeks ago you announced your proposed budget for 1981-83. The physicians who cooperated with you were rewarded with the biggest cut among providers. Their increase is being held to 4.5% throughout the biennium, in spite of federal Medicaid plan guidelines that reimbursement be "reasonable," an argument *used* by DHSS to justify 9 and 10% increases to institutional providers. These same institutional providers, those who fought the hardest, got the least cut in your 81-83 proposal.

On top of this, the University of Wisconsin Medical School budget suffered a direct cut of $1.6 million, the only major budget at the UW to actually be reduced in total dollars.

The lessons from these experiences are painfully clear.

We appeal to you only for equity and fairness. We understand and accept the need for spending reductions, but your proposal asks the few who receive the least Medicaid dollars to bear the greater brunt.

We respectfully urge, in the interests of fiscal integrity and continued effective delivery of services to the poor, that you revamp your proposals to bring greater balance among cuts for healthcare providers.

There is real concern that continued erosion of reimbursement, coupled with greater than normal "red tape" problems, will prompt marginal volume providers to leave the program and higher volume providers to limit the numbers served. An even more critical eventuality may be the pull-out of physicians from low-income areas of the state where Medicaid recipients constitute a high percentage of the practice load.

This, of course, runs in direct contradiction to your and our efforts to encourage more even distribution of physicians in the state.

Executive Committee of the Council
State Medical Society of Wisconsin

Darold A Treffert MD
Chairman of the Council

Russell F Lewis, MD
President

Albert J Motzel Jr, MD
President-elect

Timothy T Flaherty, MD
Vice-chairman of the Council

Duane W Taebel, MD
Speaker, House of Delegates

Roger von Heimburg, MD
Councilor

Correction!

MY ARTICLE, "Probable carbon dioxide embolism during laparoscopy; case report" that was recently published in the March issue of the *Wisconsin Medical Journal,* contains a serious error. Page 28, the last paragraph, 3rd line states erroneously that in the management of CO_2 embolism the patient should be hyperventilated with 100% carbon dioxide. Stated correctly, the patient should be hyperventilated with 100% oxygen (O_2). Under no circumstances should any patient or subject be ventilated with 100% carbon dioxide.

Bonnie M Tompkins, MD
Assistant Professor (CHS)
Department of Anesthesiology
University of Wisconsin-Madison
Madison, Wisconsin ■

Commentary

Do doctors live longer than the rest of us?

DO MEDICAL DOCTORS live longer than the rest of us? Medical doctors, after all, are the purveyors of medical knowledge to the rest of us. But do they follow their own advice? The answer seems to be that they do—up to a point!

Because this question has intrigued me for some time, I did a bit of research on it. And what I found was revealing and somewhat surprising. Until age 65, physicians have a significantly lower mortality rate than the rest of the population. The difference is as much as 50 percent in favor of physicians who are in their 30s, to as much as 100 percent for physicians in their early 60s. After age 65, somewhat surprisingly, physicians' mortality is anywhere from 4-10 percent higher than the rest of the population.

So, up to age 65, fewer physicians die from the things the rest of us do and by rather significant amounts. But after age 65, they die at a slightly faster rate than the rest of us.

Why should that be? One could suggest some obvious reasons. First, physicians have high job satisfaction and that is an important, though infrequently mentioned, ingredient to a healthy and long life. Second, physicians more than any other group in our society have been listening to the "Wellness Revolution." It is rare to find a doctor who smokes cigarettes anymore. And like many other Americans, physicians have altered their diets and increased their exercise and physical activity—all of these are important to prevention of disease and premature mortality. A possible third reason is that physicians have relatively high incomes so they can afford to spend more on their healthcare. And, of course, because they are physicians, they should know how to get the most for their money.

For all these reasons, it's probably not surprising that physicians do better than the rest of us in protecting themselves against premature death.

But what about the fact that after age 65 the mortality rate for physicians is higher than the rest of us. That one puzzles me! Perhaps job retirement at age 65 is signficant. Or perhaps there is some hidden occupational disease for doctors which doesn't show up until one is past the mid-sixties, much like cancer from asbestos exposure which takes 20-25 years to develop. After all, while physicians may have high job satisfaction, it is a stressful occupation. And stress over a prolonged period does finally catch up with one.

To explore those possibilities, I did a bit more research to see if life expectancy varied between the different kinds of medical doctors. Again I was surprised—because there are some notable differences: For example, specialists—surgeons, cardiologists, pathologists—live longer (on average about 14 percent) before and after age 65 than physicians who are in general practice, *ie* the family doctors! The highest life expectancy is for pediatricians, and the lowest for radiologists. There well may be something, then, associated with job stress and job risk at work. The type of doctor you are may be influencing your longevity!

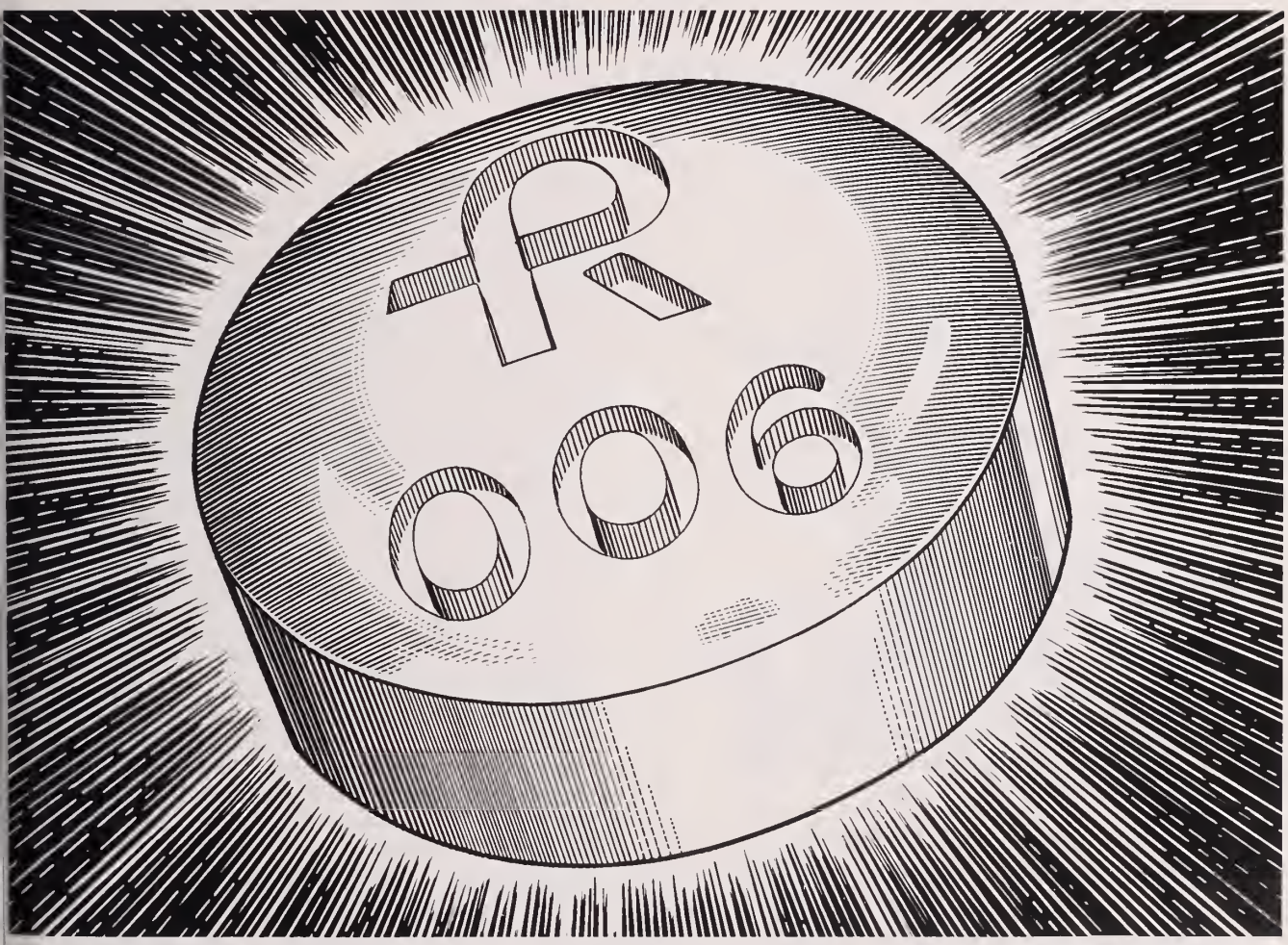
Nonetheless, doctors on the average do live longer than the rest of us—at least up to a point. Doctors are telling us to do things that are good for us—even though we may not like being told we're overweight, smoke too much, and are sedentary. Their success with preventing premature death by changing these habits could be our success, too. In any case, I still feel guilty as ever about smoking and hate myself for being annoyed with all the joggers I meet every morning as I leisurely walk my lovable, but overweight dog! (Reprinted with permission from MADISON Magazine, November 1980)

Ralph L Andreano, PhD
Professor of Economics
University of Wisconsin-Madison

This article was first read as a commentary on WHA Public Radio's Morning Edition where Doctor Andreano is a weekly commentator on health and economics issues. It is being reprinted here from MADISON magazine, November 1980 issue, with permission of Doctor Andreano.

Will your generics need a lawyer?

Beware! Many state laws, now in effect or proposed, require the identification of product, strength and manufacturer on each solid doseform to be legal for generic substitution. If you dispense unidentified drugs, after effective date of legislation, you're dispensing in violation of such laws.



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Will your generic pharmaceutical supplier be able to meet all identification requirements—especially if that supplier is not a manufacturer? Products not properly coded then violate the law! And by dispensing them, you're substituting illegally. And taking big risks.

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American Board of Family Practice has named the following Wisconsin physicians, diplomates, by passing the 11th certification examination given in 1980. They are:

Peri Lynne Aldrich, MD,* Pulaski
David Edward Atkinson, MD, Milwaukee
Paramjit Kaur Bamrah, MD, Pewaukee
Neil Nathan Bard, MD,* Richland Center
Mary S Bartholomew, MD, Milwaukee
Donald Gordon Bliss, MD, Salt Lake City, UT
Bruce A Bonde, MD, Eau Claire
David Eugene Burnett, MD,* Sparta
Marc A Carleyolsen, MD, Cedarburg
James Lynn Carroll, MD,* Tomahawk
Howard Treat Chatterton, MD,* Ladysmith
Moe Louie Chin, MD,* Watertown
Aurora M Estrella, MD, Kewaskum
Michael P Fetherston, MD,* Milwaukee
Donn D Fuhrmann, MD,* New London
Cesar Acoba Garvida, MD,* Manawa
James F Girolami, MD,* Milwaukee
Richard Gladitsch, MD, Bloomer
Matthew Paul Grade, MD, Madison
Bruce Guy Griswold, MD,* West Bend
Thomas F Heighway, MD,* Middleton
Glen Joseph Heinzl, MD,* Oconto
William Paul Hopkins, MD,* Owen
Dorothy Jaeger Jayne, MD, Waukesha
Richard Duane Larson, MD,* Fort Atkinson
John P McCue, MD,* Ashland
Richard G Nash, MD,* Ladysmith
Timothy Charles Nicely, MD, Milwaukee
Steven J Novacheck, MD, Madison
David L Olson, MD, Madison
Rodney George Olson, MD, Eau Claire
William C Piotrowski, MD, Berlin
Leon J Radant, MD,* Mauston
Melvin Harris Rosen, MD, Madison
Timothy Paul Russell, MD,* Sun Prairie
Robert P Smith, MD,* Richland Center
Gary Urban Stelzer, MD, Eau Claire
Jon C Stephenson, MD,* Superior
Alan Leonard Taber, MD,* Berlin
Randy Thomas Theiler, MD, Chilton
Rose T Varona, MD, Milwaukee
Victoria Ann Vollrath, MD,* Waukesha
Philip M Weiss, MD, Madison

American College of Surgeons recently distributed its 1981 Supplement to the 1980 Yearbook. A Milwaukee surgeon, Wayne J Boulanger, MD,* is listed as a member of the College's Board of Governors. Bruce J Brewer, MD,* a Milwaukee orthopedic surgeon, is listed as a member of the Board representing the American Academy of Orthopaedic Surgeons. Representing the American Academy of Ophthalmology on the Board of Governors is Richard O Schultz, MD,* Elm Grove ophthalmologist. Listed as Fellows who were taken in in 1980 are the following Wisconsin MDs:

David E Warner* (thoracic surgery), Appleton
Badri Nath Ganju* (surgery), Chilton
John Phillip Schmidt* (urology), Kenosha
Herbert Allen Berkoff* (thoracic surgery), Madison
John Michael Shannahan* (thoracic surgery), Madison
Ronald David Wenger* (surgery), Madison
Robert H Ciralsky (otolaryngology), Milwaukee
Marvin Glicklich* (surgery-pediatrics), Milwaukee
Stephen C Jacobs (urology), Milwaukee
Roger P Johnson* (orthopedic surgery), Milwaukee
Robert J Toohill* (otolaryngology), Milwaukee
D Maclean Willson* (surgery), Milwaukee
George E Breadon* (otolaryngology), Monroe
You-Sah Kim* (surgery), Phelps
James P Quenan* (surgery), Shell Lake
Ram K Mittal (surgery), South Milwaukee
David C Grout* (urology), Stoughton
J Garry Sack* (otolaryngology), Wausau
George J Witteman* (ophthalmology), Wausau
Carl F Moyer* (orthopedic surgery), Wauwatosa ■

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APRIL 1981

CONTINUING EDUCATION

THE 80s ARE A TIME of constant change. Therefore, it is of utmost importance for us as medical professionals to keep up with those changes involving our duties. In the last few years Continuing Education has become mandatory for you, our physician-employer, to become relicensed. Is it not important for your office personnel, your medical assistant also to keep up with the new techniques in office management, bookkeeping, collections, first aid, drug usage, lab procedures, and management of patients? The benefits of Continuing Education are innumerable. An increase in accounts receivable because of collection training, first-aid training to possibly save a life—these benefits will help your office run smoother and the result is happy and contented patients.

Where do we get good quality Continuing Education? The Wisconsin Society of AAMA sponsors two Professional Development and Advancement Seminars annually. These one-day sessions, held in November and March, offer 4-6 hours of CEU (Continuing Education Units) awardable programs. To be CEU awardable these programs must meet the rigid standards set up by the Continuing Education Board of AAMA National. These standards are: a qualified instructor, an outline to meet the objectives, and an assessment of the participant to be sure that the goals of the session are met. The local and national levels of AAMA also have planned educational programs.

Contact an AAMA member and reap the benefits Continuing Education can produce for your practice.

Karen A De Bruin, CMA
Education Chairman ■

Communications may be directed to: Sandra Doyle, CMA-C, Chairman, Public Relations Committee, AAMAI-Wisconsin Society, 929 Grove Ave, Apt 2, Wisconsin Rapids, Wis 54494.

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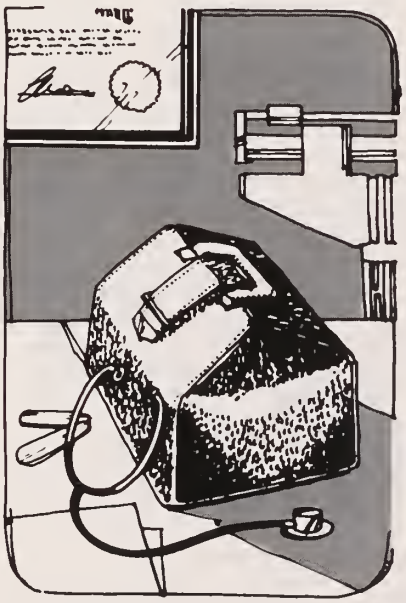

The State Medical Society of Wisconsin announces a new program designed to improve physician-patient communications and encourage greater patient feedback.

The program, entitled "Partners in Good Health," contains statement stuffers, reception area brochures, patient feedback questionaires and a certificate of participation to be displayed in the reception area.

Program brochures are available in quantity by writing to:

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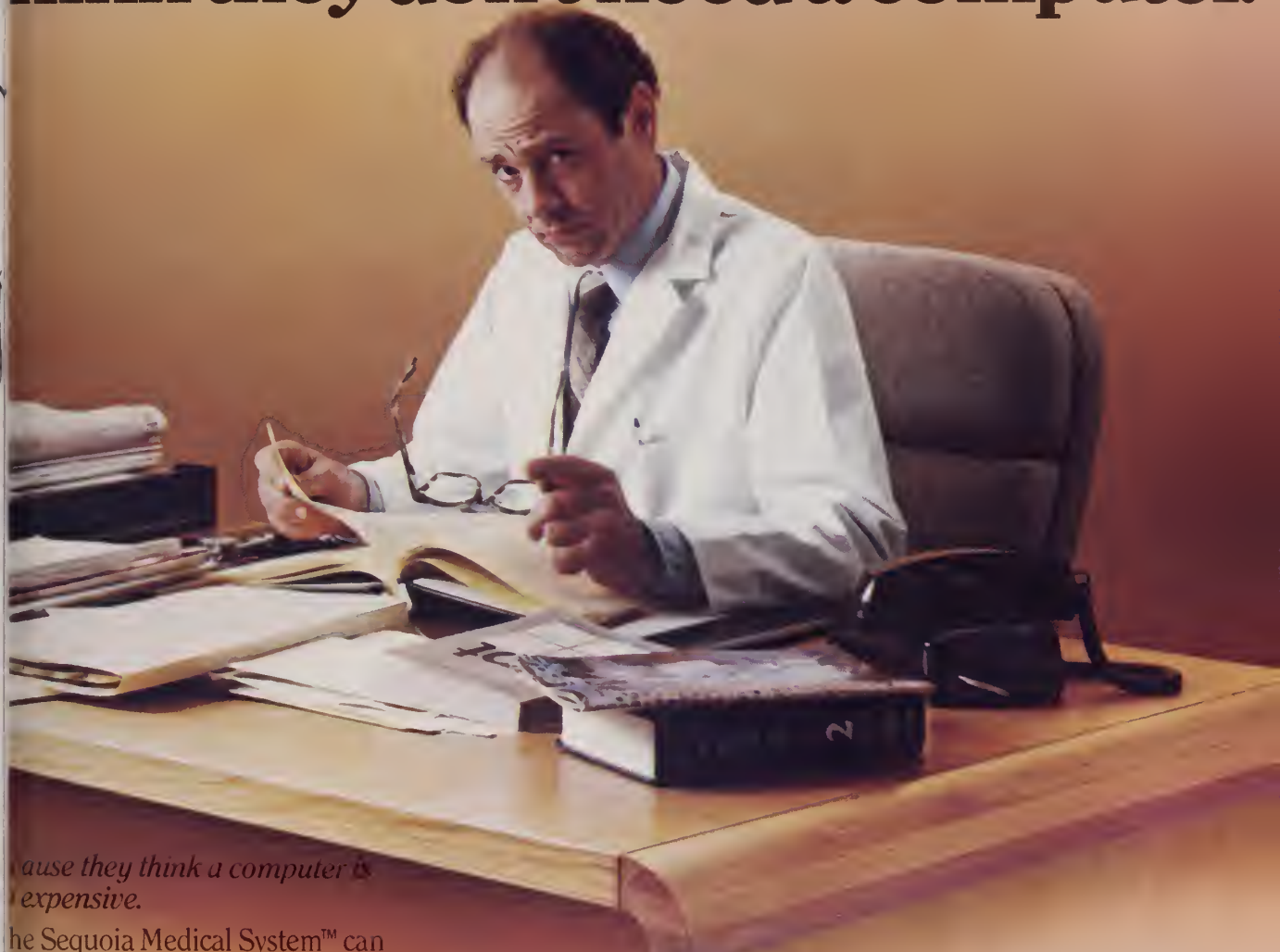

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

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PRECAUTIONS: As with other antibacterial pr tions, prolonged use may result in overgrowth o susceptible organisms, including fungi. Appro measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a n common cutaneous sensitizer. Articles in the c literature indicate an increase in the prevale persons allergic to neomycin. Ototoxicity and n toxicity have been reported (see Warning section Complete literature available on request from sional Services Dept. PML.

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DESCRIPTION

Rabies Immune Globulin (Human)—Hyperab® is a sterile solution of antirabies gamma globulin (IgG) concentrated by cold alcohol fractionation from plasma of donors hyperimmunized with rabies vaccine. Hyperab® globulin is a 16.5% ± 1.5 solution of gamma globulin from venous blood in 0.3M glycine, preserved with 1:10,000 Thimerosal (a mercury derivative). Its pH is adjusted with sodium carbonate. The product is standardized against USA Standard Antirabies Serum. The USA unit of potency is equivalent to the International Unit (IU) for rabies antibody.

This product is prepared from human venous plasma. Each individual unit of plasma has been found nonreactive for hepatitis B surface antigen using the radioimmunoassay method of counter-electrophoresis.

INDICATIONS

Treatment of rabies, once clinical disease becomes apparent, is rarely if ever successful. Rabies vaccine (duck-embryo origin, Lilly Laboratories) with or without Rabies Immune Globulin (Human)—Hyperab® should, therefore be given to all persons suspected of exposure to rabies, particularly to severe exposure. Whenever possible, Hyperab® globulin should be injected as promptly as possible after exposure. If initiation of treatment is delayed for any reason, however, Rabies Immune Globulin (Human) should be given just the same, regardless of the interval between exposure and treatment.

Rabies virus is usually transmitted by the bite of a rabid animal, but can occasionally penetrate abraded skin with the saliva of infected animals. Progress of the virus after exposure is believed to follow a neural pathway, and the time between exposure and clinical rabies is a function of the proximity of the bite (or abrasion) to the central nervous system and the dose of virus injected. The incubation is usually 2 to 6 weeks, but can be longer. After severe bites about the head and neck, it may be as short as 10 days.

After initiation of the vaccine series, it takes 2 weeks or longer for development of immunity to rabies. Since most vaccine failures have occurred in cases of severe exposure, the value of immediate immunization with preformed rabies antibody cannot be over-emphasized.

Recommendations for use of passive and/or active immunization after exposure to an animal suspected of having rabies were detailed by WHO, and by the US Public Health Service Advisory Committee on Immunization Practices (ACIP).

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CONTRAINDICATIONS

Rabies Immune Globulin (Human)—Hyperab® is contraindicated in repeated doses, once vaccine treatment has been initiated. Repeating the dose may bring about interference with full expression of active immunity expected from the vaccine. Hyperab® globulin is also contraindicated in individuals who are known to have an allergic response to gamma globulin or thimerosal.

PRECAUTIONS

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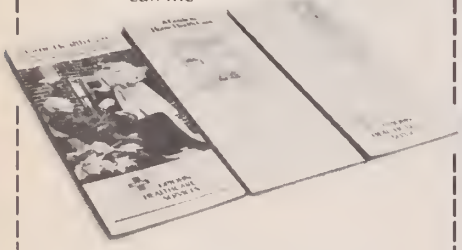

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To help the mentally ill

Charles W Landis, MD, Milwaukee, Wisconsin—*Guest Editor*

IN THE PAST several years of meetings of the State Medical Society's Mental Health Committee, it has become increasingly apparent that the most significant challenge has been to assess the unique and formidable barriers to effective psychiatric treatment. They run the gamut from inadequate funding, conflicting philosophies of treatment versus freedom, cyclical phenomena of reform and retreat, to the arbitrary exclusions and limitations on coverage for care by governmental and insurance plans.

It helps to look beyond our current frustrations to the lessons of history. There we can see how the needs of the mentally ill were repeatedly confused with society's social problems rather than seen as the health issues they were. We can look back to see how the fashion of one period falls into disfavor with the next. The zeal of reform has too often been replaced with stagnation and regression.

When Pinel followed the French Revolution with his freeing the mentally ill from shackles and dungeons, the humane era in psychiatric care began. Dorothea Dix carried on the mission in the United States as she aroused state legislatures to establish asylums befitting human dignity. In the absence of any specific treatment then, the provision of supportive wholesome environments was a significant and commendable achievement. Certainly some patients of that day may well have fared better in Dix's new therapeutic settings than some in today's Wisconsin who qualify for jail easier than mental hospitalization.

When Dix persuaded the United States Congress to make land grants to states for care of the insane, President Pierce vetoed the measure. He wrote that it would have established the principle of federal responsibility for "all the poor in all the states," thus recording for posterity that the stereotyping of the mentally ill with the nation's social ills has been shared by everyone from peon to President. Unfortunately, the mixing of the poor, the criminal and the insane in one diffuse imagery has corrupted our ability to appropriately address the unique needs of each population—in this century as well as in those past."

Reprint requests to: Charles W Landis, MD, SMS Committee on Mental Health, PO Box 1109, Madison, Wisconsin 53701 (phone: 608/257-6781). Copyright 1981 by the State Medical Society of Wisconsin.

As for the reforms sparked by Dix, they met the eventual fate of so many other reforms as the humane asylum movement stagnated into isolated, underfunded and forgotten state and county hospitals. No sporadic reforms could prevail until psychopharmacologic breakthroughs in the last 25 years brought new promise. For the first time in history it became possible to reverse the psychopathologic process with some predictability. Concomitantly, the nation became aroused with this new promise and the infusion of much federal horn blowing and offering of carrots to states that would turn away from institutional care and toward the community. In the extremism that goes with new zeal, the National Institute of Mental Health promoted the myth that chronicity would disappear with the institutions. With these institutions now gone and the federal dollar for the storefront substitutes long having done the disappearing act, we catch ourselves now dreaming a little of how fine a resource a benign supportive institution might be for some of our chronic patients. In pursuing the many virtues of treating patients in ambulatory settings in their own communities, recognition was lost that some patients would always be chronic—not just those from the old hospitals but some not yet born. It is necessary to recognize there is a certain chronic mental population unable to prosper in the social matrix of the community who could optimally function in the structured supportive society of an institution. Others could make it in the community if provided adequate support, rehabilitation, and care.

Today we see the fallout of the shortcomings of the theorists of the 1960s and the inadequacy of the continuum of care in the community. We are painfully aware of the minimally supervised patients in the mini-ghettos of converted hotels, boarding and rooming houses, and nursing homes. No longer in the census of state and county mental hospitals that have closed their doors, many of these former residents fare less well than before their release. Their living out their lives sitting in lonely rooms, on park benches or roaming statehouse grounds is mute testimony to the failures of the movement back to the community that was the fashion of the 60s.

In the eyes of clinicians eager to fulfill their mission to heal, the coming of the civil libertarian on his white charger was perceived as a contemptuous

CHARLES W LANDIS, MD since 1978 has been a guiding influence to the Committee on Mental Health, first as a member and then serving for two years as its chairman. Currently he is president of the Medical Society of Milwaukee County and medical director and chief-of-staff of St Mary's Hill Hospital in Milwaukee. Doctor Landis also is associate clinical professor of Psychiatry, Medical College of Wisconsin. He is a past president of the Wisconsin Psychiatric Association and Milwaukee Neuropsychiatric Association. Over the years Doctor Landis has served on numerous civic, governmental, and professional task forces, study and planning groups, and health organizations. Among his honors are a Certificate of Commendation from the American Psychiatric Association and a Certificate of Appreciation for Leadership in New Concepts of Care, Citation for Advancement of the Philosophy of Community Placement, Halfway House Federation of Wisconsin.

obstruction of the therapeutic process. The success in establishing new beachheads for civil rights in Wisconsin mental health statutes has proved overwhelmingly counterproductive to the well-being of many patients, their families, and their communities. With the views of civil rights zealots prevailing to block effective treatment, we reap a sordid aftermath of deaths and untold human suffering from untreated mental illness. Fortunately, across the nation we see courts finding for those who contend statutes must be structured to enable the good efforts of friends, family, professionals, and society to effectively intervene when the mentally ill cannot themselves rationally participate in plans to remedy their afflictions. We must work to see this day dawn again in Wisconsin.

In this issue of the Society's journal, members of the Mental Health Committee and other invited authors address a complex of mental health issues worthy of notice. So global is the subject, we cannot pretend to approach comprehensiveness in one issue but are appreciative of this opportunity to bring new attention to these matters. We do hope to communicate some concerns, observations, and the resolve to continue to help the State Medical Society in its leadership role in remedying the plight of the mentally ill and promoting the most efficient and effective treatment of psychiatric problems of people. The committee welcomes and solicits the ideas of all who can contribute their thoughts to this effort. ■

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Committee on Mental Health

Report to the House of Delegates: March 1981

THE MENTAL HEALTH COMMITTEE has met four times since the last Annual Meeting to discuss and take action on several issues of vital concern in the legislative and regulatory arena.

Questions about the level of care and treatment of persons in Wisconsin with chronic mental illness have been a major concern of the committee. It has supported DHSS efforts to establish a network of regional centers for the chronically mentally ill as a treatment alternative to the community neglect which has been alleged throughout the state in recent years. In addition, the committee is currently in the process of editing a *Wisconsin Medical Journal* issue devoted largely to the problems of persons with long-term mental illness.

In the Legislature the committee assisted in the enactment of AB 913 which created a "fourth" commitment standard that lessened the requirement of a "pattern of recent acts or omissions" to "a recent act or omission" as evidence of need for an involuntary commitment. That bill also lowered the burden of proof to allow "clear and convincing" rather than "beyond a reasonable doubt" decisions with respect to a jury's determination in a commitment case. Committee members also carefully followed congressional developments concerning revisions to the Mental Health Systems Act. That bill provides major funding to the community mental health center system.

Throughout the year the committee assisted the Physicians Alliance Commission by providing analysis and direction on changes in the psychotherapy provisions of the Wisconsin Medical Assistance Program. Additionally, the committee has sought to equalize the coverage of mental health services provided under private insurance plans with other medical services.

Major objectives for 1981-82

1. Monitor and have input into the development of legislative and regulatory amendments to the mental health provisions of the medical assistance programs.
2. Assist the Physicians Alliance Commission and the Governmental Affairs Commission in reviewing proposed legislation in all areas of mental health and make recommendations for the establishment of SMS legislative policy.
3. Continue the appraisal of health status of persons with long-term mental illness and impact on the development of departmental and legislative policies designed to guarantee more appropriate treatment.

The above report was accepted by the House of Delegates, March 27, 1981.

***

In the Mental Health Committee's report to the Society Council, March 25, the Council concurred with the Committee's concerns of the Governor's proposed budget recommendations for the 1981-83 biennium relating to mental health.

The Council agreed that the Committee on Mental Health should proceed to work on a redefinition of medical psychotherapy which clearly delineates that physician-performed psychotherapy is indeed different from psychotherapy performed by allied health practitioners, explaining that the Committee is of the opinion that mental health services rendered by physicians should be covered under the mandated services section of the Medical Assistance Rule and, therefore, seeks the redefinition in order to make it possible to determine psychotherapy which is medical as opposed to that which is performed by other than physicians.

Chronic mental illness, what it is and what it means

Warren A Olson, MD, Madison, Wisconsin
Director, Inpatient Psychiatry, University of Wisconsin Hospital and Clinics; Assistant Professor, University of Wisconsin-Madison, Center for Health Sciences

THE TERM, chronic mental illness, is broad and ill-defined. For many people, including physicians, it conjures up images of "bag ladies," and aging skidrow bums. It automatically stigmatizes individuals and implies the hopelessness of progressive deterioration. The term obscures the diversity of the population so afflicted and because of these ideas reduces the potential for treatment and improvement in the chronically mentally ill patient.

Patients with chronic mental illness have a wide variety of primary diagnoses and cover the entire age spectrum. Children with infantile autism or pervasive developmental disorders may fall into this category, as well as elderly people with psychotic organic brain syndromes. For the most part, though, the population with which we are concerned is that which includes individuals suffering from major psychoses, such as chronic schizophrenia, chronic recurrent affective disorders, and severe personality disorders, and usually does not include persons suffering from alcohol or drug abuse, or mental retardation, even though these may be chronic as well.

The essential feature common to all forms of chronic mental illness is impairment of functional capacity. Whatever diagnostic category these individuals fit into, or whatever specific mental symptoms they manifest, they are all characterized by a relative inability to master age-appropriate tasks.

> ***"This emphasis (on community based treatment) along with the development of effective antipsychotic medications, has resulted in a major shift in treatment patterns (and) has put significant strains on an as yet not fully developed outpatient system."***

This functional impairment may lead to an inability to live independently, an inability to sustain gainful employment, neglect of personal hygiene and health needs, a breakdown in social support systems and, in extreme cases, even to an inability to provide for basic nutrition and emergent medical problems. These patients all need assistance in providing for their own social, psychological, vocational and medical needs, although the degree of assistance in various areas may vary with time.

Historically, many attempts have been made to care for the chronically mentally ill.[1] A succession of social institutions has been proposed as the solution to the problem. Three decades ago nearly all such patients were cared for in large mental hospitals, often resulting in many years of incarceration for many of these patients. In 1955, Congress established the Joint Commission on Mental Illness and Health to evaluate service and formulate a national mental health program.[1] One result of this legislation was the establishment of a nationwide system of community mental health centers. This provided for the latest innovation in dealing with chronic mental illness, community based treatment. This emphasis on community treatment, along with the development of effective antipsychotic medications, has resulted in a major shift in treatment patterns. Over the last 20 years the resident population of state mental hospitals has been reduced by two-thirds, resulting in some 400,000 patients now seeking care in the community.[2,3] In addition, the current effort to treat as many patients as possible in the community has led to an equal number of individuals who might have been hospitalized for long-term care in the past, now being hospitalized only briefly, if at all. This trend away from residential treatment has put significant strains on an as yet not fully developed outpatient system, and a major problem has become the provision of adequate social support systems and housing. Dilapidated hotels have become home, and social isolation has led to despondency, disorganization, and violence.[3] In addition, these efforts at deinstitutionalization have led to a new phenomenon of "reinstitutionalization." Many patients released for community treatment have ended up in other chronic care facilities. It is estimated, for instance, that 22 percent of residents under the age of 65 years in skilled nursing homes are mentally ill or retarded, and of patients 65 or over, fully one-third have chronic brain disease.[4] The criminal justice system has also absorbed some of these patients. In a survey conducted by the Marquette University School of Business in the spring of 1980, jail administrators estimated that over 11 percent of inmates had serious mental problems, and there is a general feeling that in recent years there has been significant increase in a number of prisoners believed to need mental health care.[5,6]

As can be seen, chronically mentally ill patients do not fit neatly into any single diagnostic category, but represent many diseases and have many and varied courses of illness. Chronically mentally ill patients are found in many different settings in established institutions and in newer community placements as well. The large numbers and increasing

"Without the proper emphasis on appropriate service, training and research, the burden of caring for the chronically mentally ill will increasingly tax all physicians and society as a whole."

community visibility of chronically mentally ill patients has meaning for all physicians. Leadership must be provided in the attainment of several goals.

First, the public must be informed of the nature of chronic mental illness. Data that are available need to be communicated effectively by professionals. The need for and status of treatment programs for the mentally ill should be more generally shared. Professional support for public policy aimed at broadening service is essential. For instance, as yet, only about half the United States population lives in areas served by community mental health centers.[7]

Second, training in the care of chronically mentally ill patients must be upgraded for psychiatrists and for all physicians. There is currently a shortage of psychiatrists,[8] and all physicians must increase their knowledge and skills in evaluating, treating, and referring chronically mentally ill individuals. Data indicate that at least 50 percent of mentally disturbed individuals have an additional illness which requires coordinated medical care.[9] This means cooperative effort among many professionals to serve complex patients.

Third, current Medicare and Medicaid policies need to be revised in that they provide little in the way of benefits for outpatient management and encourage inpatient care in general hospitals and nursing homes. The applicability of some of these funds to better community housing and social support systems needs to be examined.

Finally, the fundamental solution to these problems, of course, lies in the eventual discovery of the etiology of the various illnesses leading to chronic mental disability, and simple and effective methods for treatment of these illnesses. To this end, vigorous public support for research in mental illness needs to be encouraged.

There is little reason to believe that these problems will be quickly alleviated. The incidence and prevalence of mental illness is expected to increase over the next two decades. The declining mortality of mentally ill individuals, the increased life span of persons with other chronic illness and its attendant psychological problems and demographic changes in the population favoring increased numbers of individuals who are at high-risk for chronic mental illness can be expected to exacerbate current conditions. Without the proper emphasis on appropriate service, training and research, the burden of caring for the chronically mentally ill will increasingly tax all physicians and society as a whole.

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Recognition and management of affective disorders by the nonpsychiatric physician

William T McKinney, MD, Madison, Wisconsin
Professor of Psychiatry, University of Wisconsin-Madison, Center for Health Sciences

THIS ARTICLE is directed toward the nonpsychiatric physician with the purpose of helping in the diagnosis and management of those affective disorders frequently seen in a general medical and surgical practice.

This article differentiates depression from the normal mood swings we all experience. It is inappropriate to use "depression" in this context since major depression is now known to be a distinct medical illness.

Depression similarly is to be distinguished from grief which refers to a collection of feelings and behaviors one normally experiences immediately after the loss of a loved one. The physician needs to be aware of the typical course of grief. There may be considerable overlap with the symptoms of depression; *eg,* anorexia, insomnia, agitation, mild weight loss, social withdrawal, a variety of physical symptoms, and the like. There are important differences between grief and clinical depression, however. Grief is usually more self-limited, and uncomplicated acute grief should generally last no longer than two to three months. However, this duration can be considerably lengthened if the grief is not dealt with properly in its acute stages. In grief, self-esteem is generally not impaired as it is in depression, and the bereaved person will soon begin to adapt rationally to the loss. While most persons who experience acute grief do not develop a clinical depression, those who do are those thought to have increased vulnerability to depression for a combination of genetic, developmental, and interpersonal reasons.

Signs and Symptoms of Depression. Most frequent signs and symptoms are:

1. *Mood complaints*—expressed as sadness, "depression," "down," "blue," doesn't enjoy anything, crying spells.
2. *Vegetative signs*—anorexia, insomnia, weight loss, constipation, and decreased libido.
3. *Cognitive signs*—trouble concentrating, indecisiveness, decreased mental acuity, lowered self-esteem, and feelings of hopelessness and helplessness.
4. *Social signs*—decreased socialization, motivation, and enjoyment.

Once depression is suspected, one must evaluate the potential for suicide. There should be no hesitation to ask questions concerning suicide, for it is a common misconception that one may increase the danger of suicide by asking about it. Suicide is one of the leading causes of death in all age groups. A family history of suicide, previous suicide tries, definite plans, severe feeling of helplessness, and lack of good social support systems are all high-risk factors.

Affective disorders are among the most commonly encountered medical problems. At any time three to four percent of the population is suffering from serious depression. Approximately 10 percent of adults will become severely depressed at some time during their lives and 10 to 15 percent of those who do get depressed will eventually suicide. Many of those who kill themselves have recently seen physicians.

It has been estimated that 15 to 25 percent of general medical patients are moderately to severely depressed. Between 15 to 40 percent of all patients who see physicians with physical complaints do so primarily suffering from emotional disturbances, especially depression.

Causes of depression. The various etiologies of depression are only superficially considered in this discussion. In some clinical depressions, one will find obvious social/interpersonal precipitants, *eg,* object loss or separation, even though these stresses might be tolerated by others. This implies vulnerability, and considerable research efforts are now underway to better understand this. In some there is strong genetic vulnerability. In others certain developmental events seem critical while in still others there is evidence of altered neurotransmitter functioning. Most depressions probably involve complex interactions among many variables. While important progress in understanding the etiology of depression has been achieved, much remains to be done.

Management of the depressed person.

1. *Recognition and diagnosis*—Compare to signs and symptoms previously given. Interview with family or significant others is often critical.

2. *Thorough physical examination and appropriate laboratory evaluations*—Depressions can be primary or secondary. The presenting symptoms may be quite similar. A secondary depression may be related to a variety of diseases involving other systems; *eg,* infections, carcinomas, medications, endocrine disorders, and the like, or other psychiatric disorders; *eg,* schizophrenia, alcoholism, organic brain syndrome. Special mention should

be made here of the importance of taking a good alcohol and drug history. Some depressed individuals seek help by increasing their consumption of alcohol, others get depressed secondary to chronic alcohol or drug abuse.

3. *Indication for psychiatric consultation in depression—All* patients who have a significant number of the signs and symptoms previously listed and in whom the diagnosis of a major depression is suspected should have a psychiatric evaluation. This does not mean that all patients who consult a physician with vague physical complaints for which no specific etiology can be detected should be referred, but refers to those patients who are "positive" for a number of the hallmark signs and symptoms of a serious depression. The usefulness of diagnosis of the subtypes of depression (not discussed in this article) and the complexity of newly developing treatment programs for specific depressions now warrant referral of these patients.

Also warranting psychiatric consultation is the patient with characterologic or chronic depression—one with typically dysphoric moods for years but usually with no discreet episode. Such patients have a chronic lack of pleasure in things, and perhaps, many unexplained physical symptoms. Their interpersonal life may be chaotic and their self-esteem moderately impaired on a chronic basis but not devastatingly so as in a severe major depressive syndrome. The psychiatric understanding of these people is changing, and they represent a heterogenous group some of which are differentially responsive to certain medications and certain psychotherapeutic approaches.

The manic patient, differing from others, typically has boundless energy, talks nonstop, has trouble slowing down enough to eat or sleep, is grandiose (may be delusional), expansive, and very disruptive. These patients are treatable and should be referred for psychiatric evaluation.

4. *Treatment modalities*—The major treatment modalities that are available to treat people with major affective disorders include medications, electroconvulsive therapy, and psychotherapies.

A. *Medications*—The most frequently used class of antidepressants are the tricyclic antidepressants; *eg,* imipramine and amitryptyline. They have documented effectiveness in the treatment of many types of depressions though not all.

A second class of antidepressants is the monoamine oxidase inhibitors (MAOI). They too are effective antidepressants and in some subcategories of depression; *eg,* the atypical depressive, may be the drug of choice. Dietary restrictions are necessary and their prescription should be closely monitored.

Lithium can be effective in the treatment or prevention of depressive episodes of manic depressive illness, sometimes in combination with tricyclics or MAOI agents in initial treatment regimens, until adequate blood levels of lithium are established. Some of these patients can ultimately be on lithium alone.

B. *Electroconvulsive therapy (ECT)*—This is being used less in the treatment of depression due to the advent of effective medication and increasing legal/political restrictions on its use. However, it remains a clinically effective treatment for the severely depressed patient and there are emergency situations where its use is strongly indicated. It can be a useful alternative for some depressed persons who cannot take medications because of side-effects.

C. *Psychotherapies*—The nonpsychiatric physician can play a very helpful role in supportive work with patients who may be struggling with a variety of stresses but who do not have full depressive syndromes. In grief, the primary care physician has an extremely important role in supporting and allowing the grieving persons to express their feelings. The use of intensive psychotherapy needs to be restricted to those with specific training and expertise in such approaches. For the person who has a major depression, the physician should be empathetic but reassure the patient that it's a treatable illness like any other illness for which he will be referred for special care.

The importance of the psychiatrist and the nonpsychiatric physician working closely together in the long-term management of these patients should be emphasized. The need for referral/consultation for the major depressions has been noted. On a long-term basis, however, many of these patients will need to be followed closely by both physicians in the development and implementation of effective treatment programs. ■

Full circle, in 20 years?

LOCAL GOVERNMENTAL units are beginning to understand the support needs of the chronically mentally ill. Both Milwaukee and Dane counties have recently taken an in-depth look at the effects of deinstitutionalization on the community at large. As a county supervisor, I am directly accountable for the provision of public sector treatment services under state and federal mandate: "The county boards of supervisors have the primary responsibility for the well-being, treatment, and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within their respective counties and for ensuring that those individuals in need of such emergency services found within their respective counties receive immediate services." 51.42(1)(b) *Stats.*

Recently the Dane County Special Committee on the Care of the Chronically Mentally Ill found that fulfillment of our obligation entails the considerable involvement of the courts, several police departments, a jail, various boards and commissions at different levels of government, and more than 20 agencies with which the county contracts for the direct provision of service. Yet only a patchwork of state and federal funds has been available for these services in recent years. Supplemental security income, Medicare, and Medicaid comprise the major federal contribution for the living arrangements and treatment of persons with long-term mental illness. The state's largest effort is through the Medicaid match and community aids, though the latter must be divided up among a variety of populations in need of service. Last year a special needs grant was allocated for Dane County's CMI and with any luck this sorely needed windfall will repeat itself next year.

One Bureau of the US Department of Health and Human Services recently recognized that the current financial effort is not nearly enough. The national plan for the chronically mentally ill calls for an encompassing "incremental fiscal improvement strategy" which is designed to eliminate widely recognized gaps in service. A new range of financial coverage would be available to ensure that patients don't "disappear" on the way to and from the hospital and as they wind their way through the countless governmental agencies and flop houses.

Yet trends in state and federal budgeting at the executive level are clearly going the other way. Concern over both the cost of inpatient and outpatient mental health services has caused a swift (though predictable) reaction in the state house and Washington. The Governor has proposed that all outpatient mental health services paid for under Medicaid be provided on a contractual basis through community mental health boards which would in turn be placed at risk for a portion of the costs. This was seen as the only "alternative" to elimination of psychotherapy as a covered Medicaid service. The President has gone a step further by proposing a federal cap on Medicaid expenditures and a drastic cut in funding for many of the programs now funded by the National Institute of Mental Health.

After the dust has settled, professional and societal arguments over which is the most appropriate treatment modality will continue. The only certainty is that there will be less money available to provide any services to a continually increasing population of persons with long-term mental illness. Already that figure is estimated to be nearly 1.7 million persons nationwide.

We've all grown accustomed to the social programs of the "Great Society" which directed the government's domestic influence towards carefully delineated problems.

Now brace yourselves for the wave of the future in governmental finance. The priorities and resultant policies will be directly dictated by the availability of tax dollars as determined by an increasingly hesitant tax-paying population. Then after 20 years or so, trends will come full circle and we will once again be forced to infuse vast amounts of money to make up for our deferred maintenance. The car will never run the same again. Why don't we try to maintain and build upon the progress which has been made to date?

Neal Neuberger
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Editor's note: Mr Neuberger is the Health Planning Coordinator for the State Medical Society of Wisconsin and was assigned to assist Dr Charles Landis in putting together this special issue on mental health. He is responsible for staffing several physician committees which interact with the health planning and regulatory process. The State Medical Society, in the last three years, has involved over 200 physicians in plan development, program review, and the promulgation of standards and criteria for Wisconsin's Certificate-of-Need and Decertification programs. Mr Neuberger also staffs the Committee on Mental Health. He recently was reelected to a second two-year term on the Dane County Board of Supervisors where he sits on the Finance Committee and formerly on the County Commission on Aging.

Some legal issues concerning access to care

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THE YEAR 1980 witnessed substantial changes in important procedural and substantive aspects of the state mental health code, Chapter 51 of the *Wisconsin Statutes.* These changes were intended to liberalize the law in such a fashion as to remove arbitrary and unreasonable barriers to the securing of desperately-needed professional psychiatric treatment for the mentally disabled.

In addition to the passage of these amendments, there have been several very significant legal decisions from both the state and federal courts directly addressing the question of the psychiatrist's role in deciding the need for treatment.

Recent legislative action. In July 1980, Chapter 336 of the Laws of 1979 became effective. Although there was considerable wrangling over technical wording during the legislative debates, this bill passed both houses of the state Legislature with overwhelming majorities, indicating strongly that there is broad statewide consensus that treatment of the mentally ill is a compelling issue for our society.

The most profound change was substantive in nature and addressed the commitment standards of the old law and the rigid criminalization of the commitment process. Rejecting this approach, the Legislature adopted as a new commitment standard the language of a Federal District court decision from Pennsylvania which departed substantially from the *Lessard* straightjacket. The new language provides that a person who is mentally ill and a proper subject for treatment may be committed if he or she evidences:

> "Behavior manifested by a recent act or omission that, due to mental illness or drug dependency, he or she is unable to satisfy basic needs for nourishment, medical care, shelter or safety without prompt and adequate treatment so that a substantial probability exists that death, serious physical injury, serious physical debilitation or serious physical disease will imminently ensue unless the individual receives prompt and adequate treatment for this mental illness or drug dependency."

This language introduces the concept that a substantial impairment of basic living skills necessary for survival is sufficient for commitment. Thus a person need not be suicidal, homicidal or a catatonic before help and treatment can be initiated.

Another substantive modification effected by the new law was the dropping of the requirement from the emergency detention section under s. 51.15 that the detaining person must know of a "pattern of recent acts or omissions" before utilizing the "gravely disabled" commitment standard. Most police officers and many treatment directors or physicians attempting to utilize this section (in the absence of overt homicidal or suicidal conduct) in the past were unable to testify to "patterns" because they lacked sufficient contact with the patient to make the necessary observations. The new language omits the "pattern" requirement and permits detention if the observer has evidence of "a recent act or omission." Because s. 51.15 applies to treatment directors' actions taken to detain patients upon the recission of a voluntary admission, it should make their task easier in terms of the quantum of evidence they must present in their petitions and in testimony.

Another enlightened new provision is the section creating what may be referred to as a "non-protesting, voluntary" admission.[1]

> "A physician of the facility submits a signed request and certifies in writing, before not less than 2 witnesses, that the physician has advised the patient in the presence of the witnesses both orally and in writing of the person's rights under sub. (5) and of the benefits and risks of treatment, the patient's right to the least restrictive form of treatment appropriate to the patient's needs and the responsibility of the facility to provide the patient with this treatment; or"

The provision is aimed at the individual, frequently seen by staff persons at inpatient facilities, who presents himself for apparent admission but who refuses to sign any documents. Through the "new" statutory procedure the treating or admitting physician may admit the patient and treat him or her thereafter as a voluntary patient. The admitting physician must, in the presence of witnesses, advise the patient orally and in writing of his rights as a voluntary patient; the provisions of the new statute governing his admission; the risks and benefits of treatment; and certain other rights. On the first business day following admission, this document is filed with the court which then appoints an attorney as guardian ad litem to interview the patient and report back to the court with a recommendation regarding the patient's status as a voluntary. If the patient has not, within seven days of this admission, signed a conventional admission form, the court must hold a hearing at which the patient, guardian ad litem, and treating physician appear to advise the court as to the patient's status. The court may then permit the status to continue, order the commencement of involuntary procedures, discharge the patient or take any other action it deems appropriate.

Several significant procedural changes appear in the new law which reveal a clear legislative intent to decriminalize the commitment procedures.

Perhaps the most obvious of these is the change of the burden of proof for all elements of such a case

from "beyond a reasonable doubt," which is the criminal standard, to "clear and convincing," a civil standard. In addition, the new law provides that the rules of civil procedure shall apply to commitments unless another rule within ch. 51 covers the subject matter. The Legislature also provided that the courts are to disregard any error or defect in the court documents or the proceedings that does not affect the substantial rights of either part. Called the harmless error rule, it is intended to assure that cases receive full hearings on their merits and to cure technical, nonprejudicial errors in order to avoid dismissals.

Recent legal decisions affecting delivery of services. In June 1979, the US Supreme Court handed down Parham v. J.R., 442 U.S. 584, a long-awaited decision involving the question of the extent to which due process is constitutionally required in commitment proceedings involving juveniles. In a nutshell, the Court ruled that the only requirement for a valid inpatient commitment of a juvenile is the clinical determination of the staff of the treatment facility that such care is necessary and appropriate:

> "It is not necessary that the deciding physician conduct a formal or quasi-formal hearing. A state is free to require such a hearing, but due process is not violated by use of informal, traditional medical investigative techniques. Since well-established medical procedures already exist, we do not undertake to outline with specificity precisely what this investigation must involve. The mode and procedure of medical diagnostic procedures is not the business of judges. What is best for a child is an individual medical decision that must be left to the judgment of physicians in each case. We do no more than emphasize that the decision should represent an independent judgment of what the child requires and that all sources of information that are traditionally relied upon by physicians and behavioral specialists should be consulted....
>
> "Common human experience and scholarly opinions suggest that the supposed protections of an adversary proceeding to determine the appropriateness of medical decisions for the commitment and treatment of mental and emotional illness may well be more illusory than real."

Not only did the court rule that the adversary due process procedures (counsel, jury trials, pleadings, rules of evidence, and the like) are inappropriate in such hearings but, further, it enunciated a ringing affirmation of the legitimacy of medical diagnostic procedures in determining medical issues and it gave renewed impetus to the concept of parens patriae.

In the case of *Rogers v. Okin (1980, 1st Cir. Ct. App* citation unavailable) decided in December 1980, the court was faced with the issue whether a committed patient had the right to refuse treatment, specifically, forced medication. In a narrow decision, the court ruled that such a right is constitutionally mandated and that there must be a finding that the patient is incompetent to make medical decisions about the need for treatment before the decision to treat may be made for him. However, the court overturned a district court determination that there must be an adjudication of incompetence in a full due process adversary hearing, holding instead that the adjudication procedures must be further litigated by the district court, and suggesting that the *Parham* decision and rationale had application to this issue on remand.

The district court decision held that, absent an adjudication of incompetency, the state could involuntarily medicate a person if an emergency existed. The district court defined "emergency" as "circumstances in which a failure (to forcibly medicate) would bring about a substantial likelihood of physical harm to the patient or others." The Court of Appeals rejected this definition as unduly rigid as it failed to include situations where a failure to promptly medicate would lead to a worsening of the patient's *psychiatric* condition. This issue was also remanded to the district court to take testimony on emergency treatment.

Although *Rogers v. Okin* is not over, it has immediate impact here in Wisconsin where a similar case is presently pending in Milwaukee County. Because of substantial differences between Wisconsin and Massachusetts commitment law, it may well be that our procedures sufficiently permit the litigation of the competency issue in a regular commitment to escape the trial court unscathed based on *Okin* guidelines.

> ***"More evidence is appearing that courts are striving to achieve a better, more reasonable balance between a person's rights and his or her health, and that to permit human suffering to continue in the face of readily available and oft-proven treatment modalities is too high a price for a person to pay for the often illusory benefits of an adversary proceeding which asks judges to make decisions which can and should be left to physicians."***

Another significant Wisconsin case which directly affected the ability of staff psychiatrist to commence commitment proceedings involving inpatients was *In the Matter of Haskins,* an unpublished Court of Appeals decision from the First District released September 8, 1980. The court ruled that the power of a treatment director or designee to commence emergency detentions under s. 51.15 (10) Stats., is not limited to those patients voluntarily admitted prior to commencement; such power extends to all patients legally admitted to the facility in any fashion. The court also held that the alternate commitment standard found in sec. 51.20 (1) (am) can be

used by the treatment director or petitioner to allege and prove recent dangerous conduct. Section (am) authorizes commitment by a showing "that there is a substantial likelihood, based on the subject individual's treatment record, that the individual would be a proper subject for commitment if treatment were withdrawn."

One of the uses to which the treatment director's authority can be put is to legally detain an individual at a treatment facility long enough for family members or others, who may have better knowledge of recent dangerous conduct to initiate a regular three-part petition.

Conclusion. The *Okin* and *Parham* cases on the Federal level and the *Haskins* case in Wisconsin demonstrate that the appellate courts are beginning to reject trial court criticism of the judgment of mental health professionals on issues involving diagnosis and treatment; more and more often the cases begin to show a disinclination to interfere in such judgments unless the record reveals overt bias by the treating teams. More evidence is appearing that courts are striving to achieve a better, more reasonable balance between a person's rights and his or her health, and that to permit human suffering to continue in the face of readily available and oft-proven treatment modalities is too high a price for a person to pay for the often illusory benefits of an adversary proceeding which asks judges to make decisions which can and should be left to physicians.

The *Parham* case is too recent to permit predictions regarding its impact in contexts other than juvenile commitments; however, it clearly expresses a constitutional law philosophy that all courts surely will consider closely in dealing with treatment issues in the future. ■

The child and the law—a clinical dilemma

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OVER THE PAST few years, trends in laws, rules, and regulations relating to children with severe emotional problems, to those with judgments of delinquency, or to those who have to be removed from their homes for some reason, have caused disruptions and misunderstandings in their communities and families.

Historically, Wisconsin has been a leader in protecting the rights of the child. The intent of statutes has been to prefer rehabilitation and remediation in preference to correctional system alternatives. Present statutes and interpretations have reversed the trend, however, back to the criminal system. Dangerousness and criminality are the only criteria offering dispositional alternatives in which the child does not control the decisions regarding his medical, social, psychological, and educational care. While the statutes define anyone under 18 years of age as a child, Chapters 48 and 51 now go to great lengths to protect children's rights through vesting children with significant authority over matters of their own fate. This has resulted in a new set of standards giving the child the final decision regarding care unless the child is judged criminal or dangerous.

This trend is exemplified well by a recent Florida headline, "Toddler Batters 22-month-old Playmate." In that case, the state's attorney related he was unable to charge a two-and-a-half-year-old, therefore recommending referral to the Division of Health and Rehabilitation "only to determine if the child is delinquent." This legalistic handling allows no opportunity to holistically handle a situation in which the child is either unwilling or unable to participate in resolution of the problem.

Our society recognizes a number of chronologic milestones associated with granting privileges and rights to individuals. The most common, the right to drive at age 16, is granted after a series of instructions and successful testing. The right to care for one's body and mind, however, is now granted on simply reaching the chronologic age of 14. It is paradoxical that parents are obliged to be responsible for the child's total well-being until age 18 while the decisions of medical, social, and educational aspects of life are now in the hands of the child at age 14.

Although laudable concern for children motivated development of state statutes, and despite their purposes to address the total welfare of children, they often bar effective treatment in their overdetermined emphasis on legal rights. We need to recognize that, by granting children rights to determine their care, we are giving them responsibilities they cannot handle. A child does not possess the maturity to consistently choose the most appropriate course of action. In the frenzy to pursue due process, legally sound dispositions are made that conflict with developmental considerations and future consequen-

ces. To further add to the dilemma, the adversary approach employed pits child against parent, child against educator, and child against self.

If improvement can be made, it would be well that family involvement and intervention could be given high priority in the remediation process. Unfortunately, we presently seem limited to evaluation and protection of the legal rights of the child.

While the law seems to go to great lengths to provide legal protection for children, it ignores the necessity for the presence of a continuum of caring and protection until adulthood. Service to the child on a one incident basis ignores the child's impoverishment for protection and guidance once having left the courtroom. Logic suggests that the child's limited capacities to accept the great personal responsibility for his health and welfare dictate that the mature judgment of a parent or surrogate prevail in the developmental years. Waiting for the child to affirm his consent for care and therapeutic intervention often is fruitless and is followed by deterioration to dangerousness or criminality.

Activation of the advisory board authorized by statute would be a positive first step if it would address these concerns. Limitations in statutes might be minimized if local communities would effect coordinated efforts of their courts, schools, and agencies in addressing the problems of children. ■

Citizens active in mental health

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FOR MORE THAN 50 years citizens in Wisconsin have been active in supporting the development of quality mental health programs. The oldest and largest of the citizen's organizations, the Mental Health Association in Wisconsin, was incorporated in 1930, although its funding can be traced to 1917 and the dreams of one man. That man, William F Becker, MD of Milwaukee, addressed the State Medical Society of Wisconsin on December 1, 1917 and called for the formation of a Mental Hygiene Organization in Wisconsin. He asked for "a movement to improve the understanding and management of the insane and defectives without and within institutions, to prevent insanity and mental defects, and to conserve mental efficiency."

For ten years Doctor Becker advocated for the development of public awareness and the foundation of a citizen's mental hygiene movement. After his death in 1927, Doctor Becker left his estate to accomplish his goals, and in 1930 the Mental Hygiene Council was formed in Milwaukee. In 1934 the Council became the Wisconsin Society for Mental Hygiene. In 1945 the Society became the Wisconsin Association for Mental Health. In 1978 the name was again changed to the Mental Health Association in Wisconsin (MHAW).

The Association presently consists of 46 local affiliates and a statewide membership of several thousand. It advocates on behalf of those who need mental health services and is not a provider of service. The organization also sponsors public education and information programs to increase public understanding and awareness; volunteer services in connection with patient programs; and advocacy efforts for individuals as well as those directed at legislative bodies. As a nonprofit group, the Association depends upon contributions and volunteers to support its projects and activities.

The Association has accomplished many of its goals over the years from the early beginning when it attempted to get increased funding for public mental health programs. In more recent years the Association was the major force behind the development of halfway house programs, inservice mental health education training of teachers, services for children and the elderly, and community outpatient programs. The Association played the major role in passage of legislation in creating Wisconsin's community-based (51.42) unified services system and the mandate for special education classes for the emotionally disturbed. The citizens' group presently operates a prevention program designed to teach people how to cope with stress and is fighting the proposal to convert part of the Winnebago Mental Health Institute into a prison facility.

Over the years there has been a partnership of professionals and citizens within the Association and with State Medical Society of Wisconsin members. Both parties have learned from each other and contributed to the progress made in mental health programs and services. On a few occasions there have been times when differences were a contrast to the cooperation that has been the hallmark of past joint efforts on major concerns and issues. The Association anticipates that an even greater partnership effort will be needed in the future.

Problems and prospects with sexuality and aging

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PHYSICIANS whose professional knowledge of sexuality has been solely based on anatomy, physiology, and pathology of genitourinary systems, have often felt unprepared to deal with sexual problems in the clinical encounter. The disparity between societal expectation of physician expertise on sexual matters and the formerly sexually deficient medical curricula, have more often than not resulted in physician avoidance of inquiry into patient's sexuality. Burnap and Golden[1] indicate that two-thirds of the physicians who obtain sexual histories note significant dysfunction in at least half of them. Those physicians who did not inquire about sexual practices estimated less than 10 percent of their patients had sexual problems. Masters and Johnson's[2] subsequent research also confirmed this 50 percent figure. Most probably, everyone could benefit from information on sexual functioning at some time during their life.

The elderly are particularly vulnerable to sexual dysfunction. Increased stresses from multiple losses, along with the effect of chronic illnesses and multiple medications, all take their toll of sexual functioning. Physicians often hold the same agist and sexist myths that pervade the society at large. Dagon[3] has described the societal sexual myths as they particularly apply to the elderly. The most destructive of these are that sexuality automatically diminishes with advancing age and ends with blissful asexuality at age 65. The corollary of this is stated that sex is only for the young, with its aesthetic narrowness which is focused only on youth as beautiful. The myth is malicious in that it assumes a one-sided view of aging as biological decline and fails to appreciate the view of aging as development. Robert Butler[4] has noted the need to expand beauty to include ". . .those individual traits that a person has made of themselves; their uniqueness, character, intelligence, expressiveness, knowledge, achievement, disposition, warmth, style, social skills, and bearing. . ." Another potent myth noted coitus as only for reproduction, with deemphasis of the part it plays in mutual pleasure and bonding. This myth was sometimes stated by the Victorians as nice girls don't, or women must submit to men's pleasure, but do not take pleasure in such things themselves. This leads frequently to anorgasmia in women, or to guilt and shame for having continued sexual feelings. Many of these myths often survive to the present day, scarcely changed from the time they were imprinted many years ago.

What are the facts behind the myths of sexuality and aging? It is first of all important to realize the tremendous diversity that the elderly represent. They cannot be subsumed under one label that describes all elderly. This error in thinking has been coined "agism" by Robert Butler. Pfeiffer[5] reviewed the Duke Longitudinal Studies and has offered the following facts. For men at age 68, about 70 percent remained sexually active and at age 78, about 25 percent were sexually active. For men, the married state was not a necessary factor, whereas for the majority of women, the availability of a sanctioned sexual partner was essential to continued coital activity. One should bear in mind that these figures are from an agist society. There are cultures around the world that imply a high social value to wisdom and aging. Leaf,[6] in his studies of the Abkhasians in the Caucasus Mountains, notes that these men were uniformly sexually active into their 80s and beyond.

What are the normal changes that accompany aging? In Masters and Johnson's[2] studies of American men and women, they noted that the peak of sexual activity occurred in the teens in men and approximately 35 in women. Thereafter, there was a slow decline. Some changes, however, were fairly uniform with aging. The major changes which commonly occur in the sexual response patterns of aging males were: (1) the longer time period of the excitement phase to achieve full erection, males needed greater use of fantasy, foreplay, and stimulation; (2) more difficulty maintaining a full erection; (3) lengthening of the plateau phase so that there is better opportunity for ejaculatory control; (4) a lessening of desire for orgasm; (5) decrease in the force and amount of ejaculate. The major changes which commonly occurred in the sexual response patterns of aging females were: (1) as with males, an increase in the excitatory threshold, so that longer time was required to obtain lubrication; (2) with thinning of the vaginal mucosa postmenopausally there was a marked lessening of lubrication; (3) increase in desire for sexual activity in late middle age, with a gradual decline of sexual interest in old age; (4) the ability to have orgasm as long as physically functional.

> ***"It is essential that elderly, like everyone else, feel desirable, wanted, and loved. . .sexual intimacy is one of the natural buffers to stress and decline. . .The physician's attitude, knowledge, and skills are vital to preserving sexual functioning in the elderly."***

Hogan[7] has suggested that a systems approach to sexual dysfunction is helpful to understand how the various factors such as illness or lack of sexual knowledge, and/or skill, misinformation, anxiety and depression have feedback loops with historical factors such as religious orthodoxy, marital problems, and sexual trauma. These factors may proceed along a final common pathway that results in an acute sexual failure, which when combined with performance anxiety, leads to the vicious circle of communication breakdowns, withdrawal, hostility, and subsequent chronic sexual dysfunctions. Dagon[3] has shown how a diversity of biopsychosocial-culture factors may impinge upon a particular person at a point in time and cause sexual dysfunction.

> ***". . .all physicians could function in the earlier levels of intervention and see the largest number of individuals."***

Annon[8] has proposed a rational continuum of increasingly skilled treatment interventions that allow each professional to select his own level of intervention, based on training and experience. This has been defined as the P LI SS IT Model, which stands for: P for permission giving; LI for limited information; SS for specific suggestions; and IT for intensive therapy. Theoretically, all physicians could function in the earlier levels of intervention and see the largest number of individuals. These individuals require careful evaluation and diagnosis and then, as Annon[8] points out, simply need reassurance and permission that they are not abnormal. Then if permission is not sufficient to resolve the continued concern, the clinician, depending on interest and training, will proceed to levels requiring more knowledge. This model has potential cost- and care-effective possibilities.

Kaplan[9] points out that only 3 to 20 percent of all the sexual dysfunctions are of biological origin. In the elderly disease states which have the greatest effect on sexual function are primarily diseases of the genitourinary tract and reproductive systems, and secondarily, diseases of the secondary sexual organs. These, of course, are followed by cardiovascular disease, respiratory disease, and endocrine disease.

One-half of older men develop benign prostatic hypertrophy. Many men frequently fear that surgical treatment will result in the end of sexuality. It is important to clarify that transurethral resection of the prostate (TURP) can produce some degrees of incompetence at the bladder neck, with retrograde ejaculation of semen into the bladder. Although this obviously interferes with fertility, it does not interfere with erection or physical sensations of pleasure. Of all the episodes of impotence accompanying this surgical procedure, they are almost all psychological in origin. Damage to the innervation of the erectal system does occur sometimes, however, with perineal approaches to the prostate.

The most common disorders affecting aging women are changes associated with target organs because of decreased estrogen. Thinning of the vaginal mucosa, secondary to estrogen deficiency, predisposes to infection with bleeding, itching, and is a common cause for dyspareunia and vaginismus. Self-stimulation is effective in preserving tone and lubricating ability, as well as an effective measure of relieving anxiety. Older women particularly need permission and information. When there are religious beliefs against masturbation, local use of estrogen creams may alleviate some of the atrophic vaginal changes. However, it is important to understand disuse atrophy and nature's dictum to use it or lose it.

Older Americans receive, on the average, 13 prescriptions annually, including renewals. Medications frequently have untoward effects on sexuality and may cause decreased libido, difficulty lubricating, or erectal failures. Medications that have commonly been associated and interfere with sexual response have been the central nervous system depressants, particularly alcohol, sedative-hypnotics, antianxiety agents, and narcotics. Other drugs that have been associated with interference are neuroleptics and tricyclics. Tricyclics may help some men by relieving depression, but in others they have actually interfered with libido and caused episodes of impotence. Of particular note is the use of the antihypertensives, especially the ganglionic blocking agents. Pentolinium, bitartrate, guanethidine, and the rauwolfia alkaloids commonly affect sexuality. Less likely to affext sexuality of the antihypertensive agents is propranolol.

Many older men with cardiovascular disease have some anxiety about sexual intercourse. Often a wife is reluctant to bring up discussion or encourage sexual activity because of fantasied coital deaths. The literature has shown that sexual intercourse rarely precipitates cardiac death. When it has been reported in connection with cardiac death, it has usually occurred with extra-marital sex or new partners. Hellerstein[10] has shown that heart rates in males with post myocardial infarctions rarely exceed 125 beats per minute during coitus with an accustomed partner. This is approximately the same effort in oxygen consumption as in walking up two flights of stairs and is easily tolerated. If there is no marked angina or congestive heart failure, a couple can usually resume intercourse within four to six weeks of an acute myocardial infarction.

One quarter of males under 40 who have diabetes mellitis have impotence secondary to the disease. This is unrelated to adequate medications or control. Females experience increasing sexual dysfunction with the duration of diabetes, contrary to males. Fifty percent of females have sexual dysfunction such as anogasmia, following a 20-year history of

diabetes. Once failure or dysfunction in sexuality is experienced by diabetes mellitis, the expectation of repeated failure is usually a self-fulfilling prophecy. The physician all too often reinforces this failure by stating the common occurrence of impotence in diabetes mellitis.

Surgical procedures such as mastectomy and hysterectomy uniformly affect sexual identity. A period of bereavement is usual and can be greatly facilitated by an understanding physician. Elderly need not develop chronic sexual dysfunctions for temporary problems.

Older people, like everyone else, have a need for sex and love. Intimacy and touching involved in sexual expression is a reaffirmation of worth. It is essential that elderly, like everyone else, feel desirable, wanted, and loved. In fact, sexual intimacy is one of the natural buffers to stress and decline, and may even help prolong life. The physician's attitude, knowledge, and skills are vital to preserving sexual functioning in the elderly.

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Barriers to treatment for private-pay patients

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Member, Committee on Mental Health, State Medical Society of Wisconsin

AN 18-YEAR-OLD college freshman, valedictorian of his high school graduating class, accomplished pianist, skilled tennis player, the pride of his family, begins to have trouble concentrating on school work he once would have thought easy, spends an increasing amount of time alone in his room, begins to believe that classmates are looking at him strangely and talking about radioactive material emanating from his body. Attempts to wash off the offending substance fail, he withdraws further, believes his body has been taken over by malevolent beings, and stops eating in an effort to drive them out. His parents bring him home for the school break, can see the change in him although he does not speak of his concerns, and convince him to see a psychiatrist. In the psychiatrist's office he acknowledges that something is very much wrong and admits that he has considered killing himself to be free of this particular torture. He is admitted to a general hospital psychiatric unit where, despite rapid institution of antipsychotic medication, he quickly decompensates to a state of catatonia wherein he remains mute, barely moving, and refusing food. The appropriate emergency treatment, electroconvulsive therapy (ECT), is given. (I shall not at this writing go into the many difficulties and sometimes impossibilities involved with gaining permission to administer this often life-saving treatment. Suffice it to say that in this case the patient indicates, somehow, his acquiescence, and his family also agrees.) Following the ECT he begins to respond to antipsychotic medication and three months after admission is able to return home. At that point his delusional system is greatly decreased, he is maintaining satisfactory nutritional state, and he no longer has suicidal ideation. However, his cognitive ability is not sufficient for him to return to college, his ability to make and retain friendships is severely limited, and his only real pleasure is playing the piano which he still does with skill but without the imaginative and crowd-pleasing talent he had shown prior to his illness. A few weeks after discharge he decides to stop taking his medication. Shortly thereafter his parents notice a general worsening of his condition, fear that he might be having delusions again, and contact his psychiatrist who informs them that the patient also has missed his last two appointments. That night he is readmitted to the hospital after taking an accumulated amount of his medicine. He indicates that he is quite depressed, that his life is miserable, that he cannot combat the forces which continue to take over his body, and that he would rather be dead than play-act a life he cannot validate. Return to neuroleptic medication, along with the protected environment of the hospital, bring another remission and the patient goes home. This sequence may be repeated several times.

Meanwhile, the patient's family goes through its own serious struggle. The parents' first fears, that they have somehow been to blame for their son's problems, are in part allayed by the psychiatrist's explanations of current thinking about the origin of schizophrenia. They are referred to Silvano Arieti's

useful book, *Understanding and Helping the Schizophrenic,* and each time their son returns home they try a little harder, but are caught up in the double bind of protecting their obviously vulnerable child and promoting his independence from them. This is an intolerable situation for most families.

In addition to the what-do-we-say-believe-now problems, the parents soon discover that their medical insurance, an up until now satisfactory group policy, has limited coverage for chronic mental illness even though it does adequately cover other chronic medical diseases. This family, although living at an upper middle class level, does not have unlimited resources and looks for ways to make the chronically ill child financially independent. Consultation with a social worker helps them apply for Social Security income which will guarantee their son an independent income as long as he is unable to provide for himself and the source of government funding is extant. Coincidental with this action the son moves into a halfway house and begins a program with vocational rehabilitation. He only occasionally plays piano now, no longer picks up his tennis racket, and has acquired a new group of acquaintances who have multiple problems themselves and do not put expectations upon him which he cannot meet. In the process of changing his funding source from parents (via third-party insurance) to government, he may or may not have to change psychiatrists. It is possible that if he changes to a government-funded psychiatrist, he will actually receive better care in the sense of a more integrated program, combining care for his medical, social, and vocational problems. Fortunately, in Wisconsin, there is now considerable cooperation and financial overlap between private and public psychiatric treatment so that many patients can continue in private care while receiving the multidiscipline benefits offered through government-sponsored or funded programs. In Wisconsin there are now privately-run programs that are accredited for the nonprivate patient who essentially receives a "scholarship" to continue in this form of care (which is frequently less expensive than public care.)

> *". . .many insurance plans continue to discriminate against the mentally ill, limiting their coverage to a much greater extent than that for patients with other chronic illnesses. As a result patients are forced to turn to governmental sources of funding. . . Traditionally, psychiatrists have not been terribly helpful to the chronic mentally ill. The law also has been at fault. . .in making the life of the chronic mentally ill and their families more difficult."*

Our patient changes his lifestyle because he has a chronic illness, an illness which happens to affect the brain but is just as much a chronic medical illness as arthritis, diabetes, and many others. If he had a different chronic illness, he would probably not be as alienated from his original medical treatment—and family—as he is with mental illness. Why is this so?

The American Psychiatric Association position statement of October 1978 states the following in regard to the chronic mental patient: "There is no more urgent concern than the needs of the chronic mentally ill who suffer from severe, persistent, or recurrent mental illnesses with residual social and vocational disabilities." This statement, of course, refers to all the chronic mentally ill. Here I would like to concentrate on those patients who fall into the "private-pay" group, suggesting that their form of suffering is often different in nature (but not in degree) from that of patients outside this category. "Private-pay" patients tend to come from families that hold relatively high expectations for their sons and daughters: college, perhaps graduate school, a good job, certain expectations as to the carrying out of adult obligations to family and society. The chronic mental patient experiences what is called "downward drift" in all these areas. His interpersonal relationships suffer severely as a result of his disease. He consequently may experience extrusion from his family and group, both socially and financially. Although he may be able to hold a job, it will be at a level below his intellectual potential and thus often unacceptable to his family and, more importantly, to himself. Even finding employment, when he is able, may be difficult due to the persistent stigma of his illness, although Title VI of the Rehabilitation Act of 1973, designed to protect individuals with mental and physical handicaps from discrimination, can be brought to bear on this situation. The population being described here includes a number of diagnoses, but the majority of these people have chronic schizophrenia; and it is in the nature of this illness that they are isolated socially and vocationally.

The wealthiest of this group go through a particularly painful process as their families shop around for a more favorable diagnosis. These patients rapidly become aware that they have failed their families' expectations because they realize how separated they are from the mainstream of common thought and activity. They then must battle their families' and their own failed expectations. Some of them get into long-term treatment at well-known psychiatric teaching centers, treatment which may well be the best there is to offer, but is still not good enough at the present level of our expertise; and we must ask how different the outcome is from that of the patient in the more traditional chronic state hospital. "VIP" treatment, by its nature, is

sometimes more harmful than helpful because of the "manners" even psychiatrists feel obliged to use in such circumstances.

Those patients who do not have limitless financial resources soon come upon another obstacle, the myth that the care of the chronic mentally ill is very expensive. This is to an extent true, but only for a very small number, those individuals who are so ill that they will never be able to take any productive place in society. Studies of insurance payments for the majority of those persons with chronic mental illness do not show these costs to be greater than the per capita costs of most other chronic medical illnesses. Nevertheless, many insurance plans continue to discriminate against the mentally ill, limiting their coverage to a much greater extent than that for patients with other chronic illnesses. As a result patients are forced to turn to governmental sources of funding, further compromising their ability to meet self-expectations.

> ***"The nonpsychiatrist physician can be a major help to these individuals through support, destigmatization, and the monitoring of medication."***

Traditionally, psychiatrists have not been terribly helpful to the chronic mentally ill. Perhaps because of our lack of knowledge about these illnesses, there has been a tendency for psychiatrists in private practice to reject these patients because they were thought to be not as intellectually challenging as the (traditional) neurotics and because there came insufficient professional prestige with this treatment. Thus society's stigma drifted over even into that profession which should have been best able to dismiss it.

The law also has been at fault, as I see it, in making the life of the chronic mentally ill and their families more difficult. In recent years there has been a failure of the law to recognize the rights of families and communities to be protected from the pernicious behavior of some mentally ill persons. Of even more importance, there has been a failure of our legal system to understand the communication forms of the mentally ill and thus to be able to respond to their actual needs. This is not surprising, as we would not expect physicians untrained in the law to understand legal communication in all its variations. The result has been patient after patient experiencing the misery of being encouraged to deny his thought mechanisms, to pretend he's "like everybody else," to be denied the right to be productive-for-the-sake-of-being-productive *eg,* refusal to allow patients in chronic mental hospitals to do farm work unless they are paid, the alternative often being to vegetate in a lonely room. The current philosophy of patients being placed in "the least restrictive environment" may turn out to be most restrictive for the individual whose anxiety is greatly increased by this action. Often a person with severe chronic mental illness experiences a decrease in self-esteem when forced to live in a community of the majority where he must constantly compare himself with others. There are times when the world of the chronic schizophrenic (this being the most common of the diagnoses I am considering) parallels the "other" world and cannot cross over, the individual being able to communicate his needs but not by using "regular" communication understandable to most people. Attempts to integrate these individuals into the community help the integrator by decreasing his fear of mental illness as a threat to himself but do not help the integrated who receives the message that he must exist, however miserably, in the parallel world—or else not exist. These particular individuals, in well-run institutions, find the freedom to maximize their potentials, isolated as they may be from the "other" world.

Fortunately, many of the above mentioned obstacles to treatment for this group of patients and for the larger group of all the chronic mentally ill are rapidly changing. Society is becoming more understanding of differences between people, insurance companies are beginning to look at their statistics more carefully, many psychiatrists are discovering a new and worthy frontier in treating chronic mental illness, biochemical and social research rapidly is bringing improved knowledge, and the legal system is beginning to understand that these patients have significant unspoken needs.

One percent of all Americans will be treated for schizophrenia at some time in their lives. More than 80 percent of patients who have a first episode of schizophrenia will show symptomatic, vocational, or social disability two years later. The nonpsychiatrist physician can be a major help to these individuals through support, destigmatization, and the monitoring of medication.

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Development of a mental health administration curriculum

Jay Noren, MD, MPH and **Robert W Peterson, PhD,** Madison, Wisconsin

SINCE THE ENACTMENT of the Community Mental Health Act in 1963, the mental health system in the United States has become increasingly diversified and complex. Community mental health centers have developed, the role of hospitals has changed, and alternatives to the more traditional methods of treating the mentally ill have emerged.

Because of this great expansion and increased diversification of the system, there has been a sharply increased need for additional expertise in administration. Clearly, substantial training and skill are needed to manage, and make rational resource allocations among, the many mental health programs.

In 1969 Glasscote[1] studied eight mental health centers and showed that half the professionals interviewed believed that the area needing most improvement was the administration of services.

Unfortunately very few educational programs exist for the training of those who are interested in mental health administration. It has been estimated that 75 percent of those who manage health institutions have had no formal management training.[2]

Although general health services management training is relevant to the mental health sector, the unique nature of mental health services justifies the development of a curriculum specifically designed to train mental health administrators.

This paper describes a study aimed at development of such a comprehensive and specialized curriculum.

METHODS. A modified Delphi technique, described by Delbecq et al,[3] was used to collect the data. This method receives input from a panel of experts who are asked to respond independently to a series of question sets, each of which builds on the results of the previous set. This process begins with a broad question and proceeds to a narrower focus with each subsequent question. The responses of the panel are then analyzed by the research team and compiled as accurately as possible so as to reflect the total input from the panel.

There were two parts to this study. In Part I, the panel consisted of 42 nationally recognized mental health professionals from seven disciplines—state directors of mental health, chairpersons of medical school departments of psychiatry, community mental health center directors, social workers, clinical psychologists, directors of inpatient mental health institutes, and client/patient advocates. Panelists were selected by a stepwise nomination process, culminating in a final step which chose 42 from among 344 potential candidates who had been nominated by individuals involved in the seven mental health disciplines. The panel members participated in 12 iterations of the Delphi, which produced the first three stages of the project.[4,5,6,7]

There were 33 panelists for Part II representing educators in mental health administration and administrators of mental health services. Their responses comprise Stages IV through VI.

RESULTS AND DISCUSSION. The aim of Stage I was to identify the goals which the mental health system should pursue. It was felt that before the educational needs for mental health administrators could be determined, the goals of the entire mental health system should be delineated. Clearly, the context in which the mental health administrator operates must first be understood before the administrative role can be defined.

Three iterations of panel responses produced 51 goals which were listed and rated on a ten-point scale as to their significance. The panel was also asked to allocate a hypothetical set of resources among these goals. The pool of resources was defined to reflect time, manpower, money, and/or facilities. These ratings allowed the determination of patterns of priorities among the goals.

The list of goals showed a wide range of concerns. The major concerns focused on continuing development of more community-based services and better coordination and integration of the delivery system. This desire for increased access to services was surprising in view of current escalating healthcare costs and concern for cost-containment. Obviously one possible approach to cost-containment is to construct barriers to access; nevertheless the panel responses run counter to this approach.

Concern was also expressed for more equitable resource deployment through better insurance coverage for mental disorders. Other goals emphasized monitoring and evaluation of program outcomes.

Several goals reflected a need for improved advocacy of consumer/client interests.

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Many of the goals underlined the need for greater administrative expertise.

Stage II identified over 300 programs, strategies, and methods for achieving the major mental health goals. Panelists also rated these programs and allocated resources among them.

Again, it was surprising that those programs related to increased access to services received the most support, since increased access to services is generally associated with increased cost. It was also unexpected to find that the programs relating to cost-containment or organizational efficiency were rated only fifth out of seven groupings.

Another trend observed was the increasing demand for provider accountability to the consuming public for services rendered. Patient rights/sensitivity programs and effectiveness evaluation methods both received considerable support from the panel.

In Stage III, the panel was shown the list of 51 goals and the associated programs, strategies, and methods and asked to develop statements of knowledge areas, attitudes, and skills which are needed by mental health administrators to achieve these major mental health goals. The panel identified 165 knowledge areas, attitudes, and skills, then rated them for importance on a ten-point scale, and determined the setting which would be optimum for achieving them, such as formal graduate education, continuing education, or work experience.

For Stage IV, a second panel described over 100 innovative educational methods which could be used to develop each of the eight top-ranked knowledge areas, attitudes, and skills.

In Stage V, the research team grouped the 165 knowledge areas, attitudes, and skills into 13 content concentration areas. These content areas were then used in Stage VI as the framework for development of the Educational Experience Modules for use in mental health administration educational programs.

The detailed results of the different stages and the complete curriculum will be published soon.

CONCLUSIONS. The final product of the study, Mental Health Administration Educational Experience Modules, will integrate the training of the mental health administrator with multiple facets of the entire mental health system. It should benefit those engaged in development of curricula for graduate programs in mental health administration, as well as continuing education.

The study will potentially serve as the starting point for more refined needs assessment in mental health services, program planning, mental health education, and education of administrators. Study results provide clarification of goals in the mental health system and underscore the importance of specialized training to prepare skilled administrators who can serve its diverse needs. Certainly such goal clarification and targeted training is essential to enhance effectiveness and efficiency of the mental health system.

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The annual BLUE BOOK issue of the *Wisconsin Medical Journal*—containing medicolegal, socioeconomic, legislative matters of direct concern to physicians in their relationships to patients, hospitals, government agencies, the Legislature, and others in the medical community—will be published in June. The *Wisconsin Medical Journal* welcomes the opportunity to provide advertising space to Society members, medical clinics, hospitals, and others involved in healthcare who desire to make their services known to the medical community. Advertisements will be accepted until May 10. Anyone wishing to participate may call the Journal office: 257-6781 (Madison area) or toll-free 1-800-362-9080 (in Wisconsin) for further details.

The mental health patient and the family practitioner

Theodore J Nereim, MD, Mount Horeb, Wisconsin
Member, Committee on Mental Health, State Medical Society of Wisconsin

THE EVER-INCREASING stress of modern life is producing ever-increasing concern. Present day economic uncertainties and social and political upheavals have greatly increased the incidence of mental and emotional stress and mental and emotional illness. We are confronted with a need for increasing our psychiatric resources. Within the forseeable future this need will not be adequately supplied. The field of psychiatry is not attracting as many young physicians as the specialty needs in order to keep pace with the demand for psychiatric service. While many medical specialties are somewhat over-crowded many psychiatric residencies are not being filled. The gap between the need for psychiatric service and the availability of that service can be expected to widen.

The family physician cannot supply all of the needs of mental patients, but he is in a position to recognize early indications of developing nervous and mental illness and to encourage the patient to seek and accept proper clinical management. Far too often the subclinical psychotic is unrecognized until a psychiatric catastrophe develops. He is often shielded by his family because they cannot face up to the existence of mental illness in the family. Too often mental illness is not considered to be an illness like any other illness but rather some sort of disgraceful reflection on the honor and integrity of the family. Very often treatment programs are interrupted due to interference from family members who feel that treatment is not necessary. The family physician usually has excellent rapport with the patient and his family. He can play an important role in encouraging the patient and his family to continue to cooperate with the treating psychiatrist.

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THE NEW PRESIDENT
Albert J Motzel Jr, MD

ALBERT J MOTZEL JR, MD, Waukesha, was installed as the 126th President of the State Medical Society of Wisconsin, March 28, 1981, during the Society's Annual Meeting in Milwaukee. Doctor Motzel, 53, succeeds Russell F Lewis, MD of Marshfield.

Doctor Motzel was born in St Louis, Missouri, and served in the US Navy in 1945 and 1946 before receiving a Bachelor of Arts degree with a major in philosophy from the University of Notre Dame in 1949. He graduated from St Louis University Medical School in 1953 and thereafter served his internship and residency in general surgery at Milwaukee County General Hospital from 1953-1958. He was licensed to practice medicine in Wisconsin in 1954. Doctor Motzel has been practicing general surgery in Waukesha since 1958 and has been a Diplomate of the American Board of Surgery since 1959.

Doctor Motzel is a clinical instructor in surgery at the Medical College of Wisconsin and is on the active medical staff of Waukesha Memorial Hospital, and on the associate attending staff of Milwaukee County General Hospital. He has been director of Medical Education at Waukesha Memorial Hospital since 1971. Doctor Motzel served as president of the Waukesha County Medical Society in 1972-1973 and has served as delegate and alternate delegate from Waukesha County Medical Society to the State Medical Society.

Since establishing his practice in Waukesha in 1958, he has actively participated in community service as a member of the Chamber of Commerce. He was president of the board of directors of the Waukesha Symphony Orchestra in the early 1960s and in the mid-70s he was appointed by the Mayor of Waukesha to the Downtown Redevelopment Task Force where he served as vice-chairman. In addition, he has served as chairman of the school board and vice-chairman of the parish council in his local parish.

Doctor Motzel is a member of the American Medical Association, Wisconsin Surgical Society, Milwaukee Academy of Surgery, Society for Computer Medicine, Association for Hospital Medical Education, and a member of the American Academy of Medical Directors. He is a Fellow of the American College of Surgeons. Doctor Motzel formerly was a director and vice-president of the Board of Directors of the Foundation for Medical Care Evaluation of Southeastern Wisconsin. Doctor Motzel served as vice-speaker of the SMS House of Delegates from 1975-1977 and as speaker from 1977-1980 when he became president-elect.

Doctor Motzel is married and he and his wife, Shannon, have nine children and three grandchildren. ■

Doctor Kempthorne to head SMS next year

A Spring Green physician, Gerald C Kempthorne MD, was elected president-elect of the State Medical Society at its House of Delegates meeting in Milwaukee, March 26-28.

The new president-elect has been active in organized medicine at state and county levels since 1962 when he established a solo family practice in Spring Green. He will assume the office of president at next year's annual meeting, May 13-15.

Doctor Kempthorne is a past president and past secretary of the Sauk County Medical Society; and he has served as an SMS councilor, chairman and member of the SMS Commission on Mediation and Peer Review, and as chairman of that commission's Impaired Physician Program since its inception in 1977.

Doctor Kempthorne is a member, past president, and past secretary of Sauk Prairie Memorial Hospital medical staff. He also is medical director of the Greenway Manor Nursing Home in Spring Green and the Black Earth Manor Nursing Home in Black Earth.

Most recently Doctor Kempthorne has devoted considerable time to the Coordinating Council for the Statewide Impaired Physician Program, serving as its cochairman, and to the Medicaid Medical Audit Committee, serving as its chairman.

Doctor Kempthorne's community involvements include serving as a past president of the Spring Green Lions Club and a member of the Board of Directors of the American Players Theatre, a national (Shakespeare) theatre center for the classics in Spring Green. Currently he is president of the River Valley School Board of Education.

In other Annual Meeting activities Albert J Motzel Jr MD, Waukesha, was installed as the 1981-1982 president, succeeding Russell F Lewis MD, Marshfield.

Duane W Taebel MD, LaCrosse, was reelected speaker of the House of Delegates and Chesley P Erwin MD, Milwaukee, was reelected vice-speaker.

Reelected to serve as a delegate to the American Medical Association (AMA) for 1982 and 1983 was Henry F Twelmeyer MD, Milwaukee. Richard W Edwards, MD, Richland Center, was elected as a delegate to the AMA for 1982 and 1983.

Elected to serve as AMA alternate delegates for 1982 and 1983 were: J D Kabler MD, Madison; Kenneth M Viste Jr MD, Oshkosh; and Walter J Woloschek MD, Wauwatosa.

The House also confirmed the election of 12 physicians to the State Medical Society's Board of Directors (formerly Council). Reelected as directors were: Wayne J Boulanger MD, Milwaukee; Irwin J Bruhn MD, Walworth; Thomas A Hofbauer MD, Menomonee Falls; William A Nielsen MD, West Bend; William P Crowley Jr MD, Madison; and Joseph M Jauquet MD, Ashland. Elected as directors were: Wayne H Konetzki MD, Waukesha; Fredrick Wood Jr MD, Kenosha; William L Treacy MD, Milwaukee; Jerome W Fons Jr MD, Cudahy; Darold A Treffert MD, Fond du Lac; and James J Tydrich MD, Richland Center.

In final action the House of Delegates:

•Eliminated the concept of unified membership for Wisconsin physicians; *ie,* physicians no longer will be required to join the American Medical Association in order to be members in their state and county medical societies.

•Voted to encourage the Wisconsin Legislature to reenact a motorcycle helmet law.

•Decided to seek legislation that would effectively deal with those who are convicted of driving while intoxicated.

•Authorized the Council to formulate guidelines for developing a fair and reasonable reimbursement system throughout the state for Medicaid as requested by the State Department of Health and Social Services.

•Called for the repeal of legislation mandating a second opinion program before surgery for Title 19 (Medicare) patients.

•Endorsed 29 cost-containment suggestions for physicians, hospitals, and patients.

•Urged that contributions from consumers of health-care, such as coinsurance or deductibles be offered as an optional component of all health insurance policies.

•Reaffirmed its support for the inclusion of comprehensive school health instruction programs for all Wisconsin schools K-12 and endorsed the minimum criteria for local school health instruction programs of the Task Force on Health Education of the State Department of Public Instruction.

A summary of all House actions, including the revised Constitution and Bylaws, will appear in the June BLUE BOOK issue. Other Annual Meeting activities are being reported in MEDIGRAM. ■

Legislation reviewed by Commission on Governmental Affairs

A bill which would eliminate mandated coverage for tuberculosis and kidney disease treatment in state health insurance policies was opposed by the SMS Commission on Governmental Affairs at its regular monthly meeting March 11. In other action, the Commission:

• Reaffirmed its support for a proposal which would prohibit smoking in certain public places and limit smoking to designated areas in others.

• Took no position on a bill that requires physicians to notify a minor's parents at least 72 hours before performing an abortion.

• Supported a measure which would add certain drug derivatives to the Controlled Substances Act that have potential for physical dependence. Senate Bill 98 would add derivatives of methylphenidate, its salts, isomers, and

continued ►

salts of isomers to Schedule II. In addition, derivatives of nalorphine and pentazocine, its salts, isomers, and salts of isomers would be included in Schedule III. The intent of the bill is to deal with a drug abuse problem involving the drug Ritalin®, which contains methylphenidate hydrochloride, and the drug Talwin®, which contains pentazocine hydrochloride. The Commission moved to support the bill.

• Supported a proposed administrative rule which would establish an Intermediate level for Emergency Medical Technicians in Wisconsin. Under the proposed rule, EMT—Intermediate personnel would be trained to perform selected skills beyond the basic support level EMT and would be examined and certified by DHSS. Control of training and operation of the EMT—Intermediate program would be under physicians.

• Reaffirmed its position of the last legislative session in opposing a bill which would prohibit anyone from charging a fee for any service rendered in completing a disability (health) insurance claim form used to enable a patient to receive his or her benefits. This legislation, supported by AFL-CIO, was introduced in the 1979 session; it passed both houses and was vetoed by the Governor. SMS discourages charging for simplified health insurance claim forms, but recognizes there are instances when charges may be appropriate. These instances include patients covered by multiple health insurance policies, the more complex forms under Workers' Compensation, and certain disability insurance claim forms. ■

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SMS objects to 4.5% Medicaid reimbursement limit

SMS offered testimony before two legislative health committees in late February regarding certain provisions in the 1981-83 Medicaid budget (Assembly Bill 66). In presenting the Society's views, SMS Physicians Alliance Director Brian Jensen stated that the budget was a "nickel and dime approach to reductions that will not result in stabilizing the Wisconsin Medical Assistance Program over time. The Medicaid budget in Wisconsin will continue to grow and increase dramatically in cost as long as three components—eligibility, utilization, and benefits—are left relatively unchecked while provider reimbursement is constrained," he said.

Jensen pointed out that the proposed 4.5% limit on physician reimbursement for each year of the biennium was inappropriate due to the fact that (1) institutional providers would receive 9 to 10% increases in each year of the biennium, and (2) the current physician "terms of reimbursement"—based upon charges to Medicare—results in Medicaid payments to physicians that are approximately 60 to 80% of normal charges and are based on data in the Medicare system which is 12 to 18 months old. Finally, the 4.5% limit ignores a provision in individual provider agreements which refers to annual adjustments according to the federal Medical Economic Index.

Jensen also urged the legislative committees to reject the Governor's proposal for a moratorium on hospital construction and nursing home beds. He called the moratorium "knee jerk reactions" to the failure of other existing mechanisms to control expansion. "The certificate-of-need law, passed in 1977, provides an appropriate prospective planning process for the costs of healthcare facilities," Jensen said. The Governor's Health Policy Council, meeting on February 20, voted 26-7 to oppose the hospital/nursing home moratorium. SMS Secretary Earl Thayer, a Council member, voted with the majority.

Another item in the budget called for transferring personnel from the decertification staff at DHSS to other areas in the Department. Jensen urged the Legislature to take this one step further and endorse the total elimination of the decertification subsection of the certificate-of-need law.

"After four years the Department has failed to develop any workable system on the decertification of hospital services, and after the expenditure of nearly three-quarters of a million dollars this unworkable program should be scrapped and attention paid to prospective facility approval," he maintained.

Other areas of the budget on which SMS expressed concern were:

- A proposal giving DHSS the authority to restrict reimbursement of certain inpatient surgery procedures to the outpatient surgical reimbursement rate. SMS is asking that this proposal be subject to legislative oversight and review since it anticipates difficulties to arise in establishing and implementing such a proposal.
- A series of provisions which would eliminate reimbursement for outpatient psychotherapy services except those provided by a 51.42 board facility or to physicians under contract with 51.42 boards. SMS charged that this proposal would inflate inpatient psychiatric admissions and virtually eliminate the more cost-effective psychotherapy in the outpatient/physician office setting.

Hearings on the Medicaid budget were held February 24 by the Assembly Committee on Health and Human Services and on February 25 by the Senate Human Services Committee. Each of these committees will make recommendations to the Joint Finance Committee which is not expected to act on the budget for another six weeks. ■

Health agencies, including SMS, support clean air bill

The State Medical Society was one of a dozen statewide health and service organizations that participated in a special news conference February 24, calling for passage of the Clean Indoor Air Bill (Senate Bill 80, Assembly Bill 80).

Speaking for the SMS and the American Heart Association was Thomas J Ansfield, MD, Madison, who said that there was a consensus among health professionals that cigarette smoking had adverse effects, not only on the smoker, but on the health of those nearby who are forced to breathe in the smoke. "There's no

continued ►

Q and A on second opinions

Here are some answers to some commonly asked questions regarding the new second opinion program of the State Department of Health and Social Services for Medicaid:

Q. In a dual entitlee case (person has both Title 18 and Title 19 coverage), can a physician forego the second opinion and accept Title 18 payment in full?

A. Yes. Title 18 is not affected by the second opinion program but DHSS will monitor Title 18 claims to determine the frequency of such occurrences.

Q. If a physician chooses not to obtain a second opinion, but chooses to proceed with the surgery, will other providers (such as anesthesiologists and hospitals) be reimbursed by Title 19?

A. Yes. The physician recommending the surgery is responsible to see that the second opinion program is complied with and only he/she is at risk if a decision to disregard the program is made. ■

question that persons with heart or lung disease, allergies, or asthma are most vulnerable, as are the very young and the elderly," he said.

If the bill passes, smoking would be prohibited in certain public places and would be limited to designated areas in others. All tavern and small restaurants (seating capacity less than 50) where separation would be ineffective would be exempt, but stores, places of employment, public buildings, and larger restaurants would be included.

State legislators participating in the news conference said they thought the bill had a much better chance of passing this year because stronger bipartisan support for the measure existed. SMS supported a similar bill in the last legislative session and the SMS Commission on Governmental affairs and Committee on Environmental and Occupational Health both recently reaffirmed their support for the measure. ■

SMS asks for temporary halt in emergency services assessment

SMS Health Planning Commission Chairman Guenther Pohlmann, MD, Milwaukee, has petitioned the State Bureau of Environmental Health to "temporarily cease" from conducting site surveys of hospital emergency rooms in the state until it has formulated a categorization scheme for emergency services statewide.

A state law passed in 1977 requires that the Department of Health and Social Services (DHSS) identify and prepare a list of emergency room service capabilities in all hospitals in the state in order to ensure that no hospital provides a service beyond its capability.

In a letter to DHSS Secretary Donald Percy, Doctor Pohlmann disagreed with the Department's intent to allow DHSS staff to make decisions regarding delivery of medical services without sufficient input from local health professionals.

SMS and representatives of its Section on Emergency Medical Services have offered their cooperation in performing the on-site surveys and have suggested to DHSS that it consider contracting with the State Medical Society to do some of the functions now proposed to be undertaken by Department staff. ■

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Speakers forecast increase in healthcare competition

If there was one thing everyone agreed with at the February 27 Health Planning Conference, it was that regardless of whether we see specific pro-competition legislation passed during the Reagan administration, we will see an increase in competitive forces in healthcare among physicians.

John Tillotson, vice-president of the InterStudy policy research group, said that a surplus of physicians during the '80s and '90s will force physicians to compete. We are already beginning to see the effects of a physician glut, he said, as physicians increasingly are organizing themselves into competing groups such as HMOs and IPAs. Employers, too, will play an important role as they seek to cut healthcare costs and find ways to enable employees to exercise more choice in health benefit programs.

Colin Rorrie, director of the Federal Bureau of Health Planning, warned that while there may be a shift away from traditional regulatory mechanisms and return of some power to the states within the next four years, there will be some new regulatory thrusts the healthcare industry will have to deal with. He outlined four key "regulators" of healthcare during the '80s: those who control capital; business coalitions concerned about declining profits in the face of increasing healthcare costs; human services shortages; and the government.

This year's Health Planning Conference, sponsored by the State Medical Society of Wisconsin and the Wisconsin Hospital Association, drew more than 60 physicians, hospital chief executive officers, and others. ■

Audit of Title 19 providers

Twenty-five carefully selected physicians whose patterns or service, laboratory tests, or x-ray frequency is cause for investigation are included in a special Medicaid audit being undertaken by the State Department of Health and Social Services. DHSS says prosecutions for abuse or fraud may result from the audit which is being conducted for the Department through an independent contractor. ■

DHSS concurs with CON threshold increases

The State Department of Health and Social Services has agreed with the State Medical Society's proposal to raise capital expenditure thresholds under the state's certificate-of-need law by 20%. Under the agreement, which has been forwarded to the Legislature's Joint Committee on Finance for final action, the proposed CON threshold for a single piece of clinical equipment would increase from $117,000 to $140,000 and the threshold for two or more pieces of related clinical equipment would increase from $150,000 to $180,000. SMS requested the 20% threshold increases in light of overall 20% increases in both the medical care and physician services components of the Consumer Price Index since July 1979. It is anticipated that the Joint Committee on Finance will deal with the recommendation in the 1981-83 bienniel budget deliberations. ■

PAs may be illegally prescribing drugs, MEB says in letter

The State Medical Examining Board has stated that physician's assistants who are writing prescriptions are practicing beyond the scope of their practice defined in Wis. Adm. Code Med. 8.09. The Board stated in a special communication to physician's assistants, supervising physicians, and registered pharmacists in March that Wis. Adm. Code Med. 8.09 prohibits physician's assistants from prescribing any drug, even under the supervision of a physician. That chapter reads: "None of the provisions of this chapter shall be construed to permit the independent prescribing or dispensing of any drug, or the practice of acupuncture in any form by physician's assistants."

The Board further stated that "if a physician's assistant is writing prescriptions for *any* prescription drug, he or she is violating state law as well as Medical Board rules."

"If a physician's assistant is writing prescriptions for a controlled substance, he or she is violating State and Federal law. Any supervising physician allowing a physician's assistant to write prescriptions would appear to be a party to that crime. Any pharmacist knowingly filling such a prescription would appear to also be in violation of the law."

The position of the Board is the same whether the physician's assistant is signing his/her own name or signing the doctor's name or signing any combination of the two. ■

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The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for January 1981.

Unrestricted

SMS Members; MDs Roy J Dunlap II; Larry A Lindesmith; Walter E Clasen; Vytas K Kerpe; RL Waffle; Kenneth Strebe; Roy B Larsen; Alfonso G Tamayo; Ernest L MacVicar; Carl Eisenberg; Robert D Heinen; Sverre Quisling—*Voluntary Contributions*

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Leland Pomainville, MD—*Museum of Medical Progress Endowment Fund*

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JS Huebner, MD—*Florence Scheer*

State Medical Society—*RT Thompson, MD; HI Okagaki, MD; DJ Walter, MD* ■

BROWN: Doctors, news media air views on medical reporting in Green Bay

If physicians would talk to a reporter, the same concise, factual way they talk to their patients, medical news stories would be improved, better balanced, and more easily understood by the public.

That was the view of one television reporter who gathered with physicians, hospital representatives and other news media personnel for a "no holds barred" medical-media forum March 5 in Green Bay. Sponsored by the Brown County Medical Society, the purpose of the evening was to discuss areas of concern or disagreement among those persons engaged in news reporting, medicine, and hospitals.

All of the media representatives agreed that while much improvement has occurred between physicians, hospitals, and media, some substantial problems still exist, among them: finding a physician or hospital representative who is willing to speak on an issue, and *before* the deadline.

A list of physicians, in different specialties, who were willing to comment on certain issues to the press, was requested by all the media representatives.

Jack Guthrie, MD,* Green Bay, and chairman of the Public Information Committee of the Brown County Medical Society, pointed out that physicians can't always give a major dissertation on a subject, without notice, between patient visits.

"We want to communicate," Doctor Guthrie said, "but our first concern is with the patient, the doctor-patient relationship is a very *private* thing."

This view was echoed by Jim Marshall, director of Communications and Development at St Vincent Hospital. "It's a balance between the public's right to know and the patient's right to privacy," he said. "And if the MDs and hospitals are going to err, they are going to err on the side of the patient's right to privacy."

Jim Blue, representing WFRV-TV in Green Bay, urged physicians and hospital public relations personnel to school themselves in the art of talking before a camera. Television is a very intimidating medium and one with many inherent shortcomings, he explained. "The majority of people depend on television as their major source of news and, unfortunately, we have the least amount of time to tell it in."

"We need simple explanations to complex issues," Blue said. "Medicine, like other sciences, needs a lot of qualification, but TV can't allow this."

Blue, along with other media representatives present, urged physicians and hospital representatives to let reporters know when misleading stories or ads appear in the paper and on television. "We aren't trained medical experts and we depend on you to make our stories accurate," he said.

MILWAUKEE: The Medical Society of Milwaukee County (MSMC), March 2, came forth with its own alternatives to proposals made by staff of the Southeastern Wisconsin Health Systems Agency (SEWHSA) for closure and consolidation of Milwaukee area hospital services. Charles Landis, MD,* Milwaukee, president and chairman of the board of MSMC, offered a number of suggestions, the most significant of which are keeping central city hospitals open, including Family and Children's hospitals; and closing Milwaukee County General by consolidating its services in the new Froedtert Hospital.

Doctor Landis emphasized that physicians' input had not been sought in the planning process to date. "There is something terribly wrong with a health planning process that ignores the guidance of physicians and other medical professionals," he said.

As a result of massive public outcry against its proposals, SEWSHA announced March 5 that it would abandon proposed guidelines on hospital growth and organization and instead focus on four problem areas, developing a task force on each. The four areas for study are: all downtown hospitals; Milwaukee Children's Hospital and other pediatric services; all osteopathic hospitals, and the question of regionalizing healthcare.

MONROE: Paul Jacobson of the SMS-PA staff spoke to the members of the Monroe County Medical Society at its meeting February 12 in Tomah. He discussed health issues to be considered by the State Legislature and also showed the SMS videotape, "The SMS: A Look From the Inside."

WINNEBAGO: Attorneys Jeffrey Kravat, Madison, and Thomas Hughes, Oshkosh, spoke to 38 members and four guests at the Winnebago County Medical Society meeting held in Oshkosh, February 5. Attorney Kravat spoke regarding the malpractice situation in Wisconsin with special reference to the Patients Compensation Panels. Attorney Hughes spoke regarding relationships between attorneys and physicians.

WINNEBAGO: At the March 5 meeting of the Winnebago County Medical Society, held in Neenah, Timothy Flaherty, MD* lead a discussion on resolutions to be introduced to the House of Delegates at the SMS annual meeting held in Milwaukee in March. Members of the Society's Auxiliary were present to get approval of their project involving the lending of automobile seats for newborn infants. The 29 members who were present approved the infant seat program and contributed money to solidify its support.

RACINE: The Racine County Medical Society, as of March 1, 1981 has a new executive secretary and legal counsel. Attorney John M Bjelajac succeeds Attorney Gilbert J Berthelsen who has held the position for many years. Attorney Bjelajac's mailing address is PO Box 592, Racine, Wis 53401. ■

Membership Directory UPDATE

Prepared from the February 26, 1981 Membership Report for updating the 1980-81 Membership Directory

County Medical Societies

Changes in Presidents (P) and Secretaries (S)
(See pages 89-90-91 of Membership Directory, January issue)

New	*Old*
ASHLAND-BAYFIELD-IRON	
S—Edward M Vernier, MD 2101 Beaser Ave, #9	S—Paul Van Pernis, MD 2101 Beaser Ave, #2
BROWN	
P—Louis D Philipp, MD 704 S Webster Green Bay, WI 54301	P—Raymond A McCormick, MD PO Box 1221 Green Bay, WI 54305
CHIPPEWA	
P—Romeo B Sangalang, MD	P—Romeo B Sangaland, MD
DODGE	
P—James S Berry, MD 130 Warren St	P—Norman J Schroeder II, MD 1200 Center St
S—Vicki R Prell, MD 130 Warren St	S—James S Berry, MD 707 South University Ave
GRANT	
P—John M McKichan, MD	P—C L Steidinger, MD
S—Robert E Stader, MD 235 North Madison Lancaster, WI 53813	S—John J David, MD Cassville, WI 53806
IOWA	
PO Box 185	S—Harald P L Breier, MD 207 Main St
JEFFERSON	
P—John S Garman, MD 144 W Madison St Waterloo, WI 53594	P—Filemon C Yao, MD Satinwood Lane Whitewater, WI 53190
JUNEAU	
S—Jack Strong, MD 1040 Division St	143 Division
KENOSHA	
S—Anoo P Patel, MD	S—Anoo P Patez, MD
POLK	
S—William W Young, MD 104 Adams St South St Croix Falls, WI 54024	S—Herbert A Dasler, MD 127 Keller Ave, North Amery, WI 54001
PORTAGE	
Stevens Point, WI 54481	P—Philip K Hacker, MD 2501 Main St Portage, WI 54481
RACINE	
ES—Mr John M Bjelajac	ES—Mr Gilbert J Berthelsen
RICHLAND	
P—Dale F Sinnett, MD Rt #2, Box 32A	P—Kilian H Meyer, MD 1313 West Seminary St
WALWORTH	
S—James V Seegers, MD 104 S Wisconsin St Elkhorn, WI 53121	(addition) Walworth, WI 53184
WOOD	
P—Robert M Heywood, MD 1000 N Oak Ave Marshfield, WI 54449	P—Charles F Wood, MD 1221 48th Street, South Wisconsin Rapids, WI 54494

NEWS YOU CAN USE

HEALTH INSURANCE COVERAGE FOR SUICIDE ATTEMPTS. An Appleton psychiatrist has brought to the Society's attention that some health insurance policies do not cover treatment resulting from unsuccessful suicide attempts. The physician feels that this exclusion is unfair, a further detriment to the mental health of this type of patient, and a failure on the part of insurance carriers to recognize a significant and growing health problem. This matter was discussed at the March meeting of the SMS Governmental Affairs Commission which recommended that Society Secretary Earl Thayer send a letter to the Insurance Commissioner noting "that there may be some insurance policies that do not cover treatment resulting from unsuccessful suicide attempts." The Commission further advised the Society "to oppose this kind of exclusion because the attempts are an expression of mental illness." ■

Obituaries

✓County, State, and AMA members

Michael J Bonacci, MD, 84, Mellen, died Feb 2, 1981 in Ashland. Born Feb 7, 1896 in Hurley, Doctor Bonacci graduated from the St Louis University School of Medicine in 1921 and served his internship at St John's Hospital, St Louis, Mo. Doctor Bonacci practiced medicine in Hurley, Wis, from 1924 to 1957. Surviving is a son, Robert of Mellen.

✓**William A Taylor, MD,** 91, Portage physician since 1919, died February 8, 1981 in Portage. Born March 13, 1889 in Plover, Wis, Doctor Taylor graduated from Rush Medical College, Chicago, in 1916. During World War I he served as an army surgeon in France. In 1919 he began his medical practice in Portage and served on the medical staff of Divine Savior Hospital until his retirement in 1976. He was granted life membership in the State Medical Society of Wisconsin in 1968. Surviving are three sons; William Jr, Winfield, Kansas; and Dr Stewart F and Dr Donald J both of Portage.

Hugh Worthing, MD, 91, Sheboygan, died Feb 14, 1980 in Sheboygan. Born Oct 12, 1889 in Oakfield, Wis, Doctor Worthing graduated from the Northwestern University School of Medicine in Chicago. Doctor Worthing practiced medicine in Sheboygan from 1921 until his retirement in 1966.

✓**John T Sprague, MD,** 70, Madison, died February 23, 1981 in Madison. Born May 11, 1910 in Athens, Ohio, Doctor Sprague graduated from the University of Cincinnati Medical School in 1934 and served his internship at University Hospital, Columbus, Ohio. He served in the United States Army from 1942-1945. He was a member of the medical staff of the East Madison Clinic and St Mary's Hospital in Madison. Doctor Sprague had served on the SMS Commission on Medical Care Plans from 1950-1977 and on the WPS board of directors from 1977 until his death. He was a member of the International College of Surgeons and of the Wisconsin Society of Obstetricians and Gynecologists. Surviving are his widow, Emily; one son, Jack of Madison; and a daughter, Mrs William (Patricia) Best of Monona, Wis. ■

fetal alcohol syndrome

A brochure, "Alcohol and Your Unborn Baby" (in English and Spanish versions), published by the State Medical Society of Wisconsin for physicians and patients now is available in quanity by writing to:

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Prepared and distributed by the State Medical Society of Wisconsin

Physician Briefs

*Physician members of State Medical Society of Wisconsin

Harold F Hardman, MD, PhD,* professor and chairman of the Department of Pharmacology and Toxicology at the Medical College of Wisconsin (MCW), has been elected to serve as president of the American Society for Pharmacology and Experimental Therapeutics (ASPET). He will begin his role as president-elect in July 1981. As president of the largest society of pharmacologists in the world, Doctor Hardman will have an active role in determining national policies for the support of basic medical sciences. He will maintain an office and staff in Bethesda, Md during his term of office. Doctor Hardman will be the fourth Wisconsin scientist to serve as president of ASPET since 1909 when the Society was founded. Harry Beckman, MD, Doctor Hardman's predecessor as chairman of pharmacology, also achieved this honor in 1956. Both Doctors Beckman and Hardman served as editors of the *Wisconsin Medical Journal's* COMMENTS ON TREATMENT feature some years ago.

Joseph E Trader, MD,* Manitowoc, recently was inducted as a fellow of the American Academy of Orthopaedic Surgeons at the group's 48th annual meeting held in Las Vegas.

Peter Timmermans, MD, recently opened his medical practice in Algoma. He graduated from the University of Western Ontario Medical School and served his internship at Mt Sinai and St Michael's hospitals both in Toronto, Canada. Prior to moving to Algoma, Doctor Timmermans practiced medicine in Terrace Bay, Ontario, Canada.

Michael S Mayron, MD, Minocqua, recently joined the medical staff at Eagle River Memorial Hospital. He graduated from the University of Illinois Medical School and served his internship at St Louis University Hospital in Missouri. His residency was completed at the University of Illinois Hospitals in Chicago.

Edwin L Bemis, MD,* Milwaukee, recently was informed that he was named vice-president of the American Physicians Art Association at its annual meeting held in Texas. Doctor Bemis who has a wide interest in art, had his painting entitled "Autumn Glory" on exhibit in the Creighton Art Gallery in Omaha, Neb in 1980. The painting received a "masters award" at the annual meeting of the American Physicians Art Association in 1980.

Edward Glazier, MD* formerly of Waupaca, recently joined William McInnis, MD at the Marion Clinic in Clintonville. Doctor Glazier graduated from George Washington University of Washington, DC and interned at Decatur County Hospital in Illinois. Doctor Glazier practiced abroad in missionary medicine from 1959-1967. Prior to joining the Marion Clinic, he had worked as an emergency room physician at Clintonville Community Hospital.

Homer H Russ, MD* is now the medical director of the Department of Radiation Therapy at the Marshfield Clinic in Marshfield.

William O Myers, MD,* Marshfield, recently was appointed to the seven-member executive committee of the North American Coronary Artery Surgery Study steering committee. Doctor Myers is a cardiovascular surgeon at the Marshfield Clinic and co-principal investigator for Marshfield Medical Foundation in the study program.

Kenneth L Ubben, MD,* Rhinelander, recently became a diplomate of the American Board of Dermatology Inc. Doctor Ubben, a member of the Bump Medical Group, graduated from the University of Iowa School of Medicine.

Gregory L Darrow, MD,* has joined Rocco J Vitacca, MD,* in partnership at Palmer-Greens Medical Associates, Janesville. Doctor Darrow, a board certified family physician, has practiced with Doctor Vitacca since November 1978. Prior to practicing in Janesville, Doctor Darrow was engaged in family practice in Terre Haute, Ind.

Richard F Mattingly, MD* of Whitefish Bay has been elected president of the Society of Pelvic Surgeons, a prestigious international group of the foremost experts in the field. Doctor Mattingly is professor and chairman of the Department of Gynecology and Obstetrics at the Medical College of Wisconsin (MCW), Milwaukee. The Society is comprised of current authorities in the three disciplines of pelvic surgery: gynecology, urology, and general surgery. Membership is limited to 55 active members; although the total membership is 125. The authorities in this field have continued to take leadership positions in the 28-year-old Society. The Society of Pelvic Surgeons was founded by 20 leading US physicians to exchange ideas regarding various phases of pelvic surgery and to influence the teaching and practice of pelvic surgery.

John P Hermann, MD,* Sheboygan, recently was certified by the American Board of Urology. Doctor Hermann has been in practice at the Sheboygan Clinic since July 1979 and is on the medical staff of St Nicholas and Sheboygan Memorial hospitals.

Edward J Kramper, MD of the McFarland Family Physicians, has announced that two physicians, Keith Jesiolowski and Duane Schultz, will be joining his medical practice. Doctor Jesiolowski graduated from Creighton University School of Medicine in Omaha, Neb, and is currently completing his family practice residency at Creighton-St Joseph Hospital. Doctor Schultz also is a graduate of Creighton University School of Medicine, and is completing his residency in family practice at Creighton-St Joseph Hospital in Omaha.

David L Sovine, MD,* Shorewood, is the co-author of a book entitled "Textbook of Biological Feedback" which is due for publication April 1981. Doctor Sovine co-authored the book with Mariella Fischer-Williams, MD and Alfred J Nigl, PhD. The book was published by Human Sciences Press in New York. ■

St Joseph's Hospital, Marshfield, Rehabilitation Unit has received a three-year reaccreditation from the national Commission on Accreditation of Rehabilitation Faciliites (CARF), according to an announcement by David R Jaye, hospital president. The reaccreditation follows a two-day visit by a CARF team, on December 18-19, 1980, when the unit itself, the purpose of the service, its organization, services, personnel, records, and relationships were closely examined. The unit provides care and services to restore physical capabilities of patients who have become disabled by disease or accident. St Joseph's Hospital, one of six in Wisconsin to hold CARF accreditation, first received it in 1975.

Western Wisconsin Medical Foundation Inc recently elected Thomas R Terhorst, MD,* LaCrosse, as its president. Doctor Terhorst, a St Francis Medical Center radiologist, completed his residency at the University of Minnesota Affiliated Hospitals. He succeeds Abbas Rahimi, MD.* Reelected as vice-presidents were MDs John Ujda* and Asghar Oliai* both of LaCrosse; secretary, John F Pederson, MD,* LaCrosse; and treasurer, David L Morris, MD* of LaCrosse.

Doctors Clinic Ltd of Two Rivers will become affiliated with the Fox Valley residency program based in Appleton in July. The physicians will be sent to Two Rivers on a two-month rotation basis from the Fox Valley residency program. They will work under the guidance of an associate doctor at Doctors Clinic and Two Rivers Community Hospital. Residency director is Max H Goodwin, MD.* The first group of physicians to be assigned to Two Rivers includes MDs Peter A Sanderson, Theodore F Vonck Jr, Christopher Watson, Michael A Krueger, Steven J Bahrke, and JoAnn Watson.

Elmbrook Memorial Hospital, Brookfield, recently announced the election of new officers of its medical staff. They are MDs Lawrence Burkert,* chief-of-staff; John Vondrell,* vice-chief-of-staff; William Martens,* secretary-treasurer; Frank Ziehl,* chief of inhospital service, and Mark Popp,* physician representative to the board of directors. Reelected as department chiefs are MDs Walter R Schwartz,* obstetrics and gynecology, and J Douwe Rienstra, family practice. Continuing as members of the medical staff executive committee are MDs Donald M Luedke,* chief of the Department of Medicine, and John Blackwood,* chief of the Department of Surgery.

St Joseph's Hospital, Wauwatosa, recently honored four of its medical staff for 25 years of service to the hospital. They are MDs John M Bareta,* Milwaukee; William J Buggy,* Wauwatosa; Addis C Costello,* Wauwatosa; and Thomas F Foley,* Marinette.

St Marys Hospital Medical Center, Madison, recently announced the election of Gerald J Derus, MD* as its chief-of-staff. Doctor Derus served as assistant chief-of-staff in 1979 and 1980. Elected to serve with Doctor Derus are James W Rose, MD,* assistant chief-of-staff, and Ronald D Wenger, MD,* as secretary-treasurer.

Milwaukee Catholic Physicians' Guild at its recent annual meeting installed the following officers: MDs John P Mullooly,* Wauwatosa, president; John C Linn,* Shorewood, secretary-treasurer; William J Buggy,* Wauwatosa; Anthony F Cafaro,* Elm Grove, and Uriel R Limjoco,* Menomonee Falls, directors for three-year terms. Board members include MDs Francis G Scherman* and Henry M Waldren,* both of Wauwatosa; Bernard J Klamecki,* West Allis; Stanley A Korducki,* Milwaukee, and James M Kenney and Donald E Chisholm* of Elm Grove. Doctor Chisholm, immediate past president of the guild, also is a delegate to the National Federation of Catholic Physicians' Guilds.

Madison General Hospital's medical staff will present its tenth annual spring medical symposium Thursday, May 7, in the hospital's conference room. Registration starts at 9:00 am. Opening remarks at 9:40 am. At 9:45 am John J Ouellette MD* will present a paper entitled "Emergency Management of Summer Bites and Stings." He will be followed at 10:30 am by Gene Musser MD,* John Mullin PhD, and Ken Harkins MS who will discuss "Causes and Prevention of Exertional Heat Injuries." Doctor Mullin is Program Director, MGH Center for Health Promotion; and Mr Harkins is an Exercise Physiologist. Following a break at 11:15 am Hugh L Moffat MD will talk on "Summer Viruses and Traveler's Diarrhea" starting at 10:30 am. At 12:15 pm Larry R Lantis MD* will present "Sun, Water, Humidity, and the Skin." Lunch will be served at 1:00 pm. The afternoon program starts at 2:00 pm with the following presentations: "Submersion Accidents" by Ronald D Stewart MD, Medical Director, Emergency Department, Presbyterian-University Hospital, Pittsburgh, Pennsylvania; 2:45 pm—"Appraisal and Management of Facial Injuries" by Stephen A Bernsten MD; 3:00 pm—break (Bolz Auditorium); 4:00 pm—(keynote address) "Physician Surrogate: Where to From Here?" by Ronald D Stewart MD, Pittsburgh. Adjournment at 5:15 pm.

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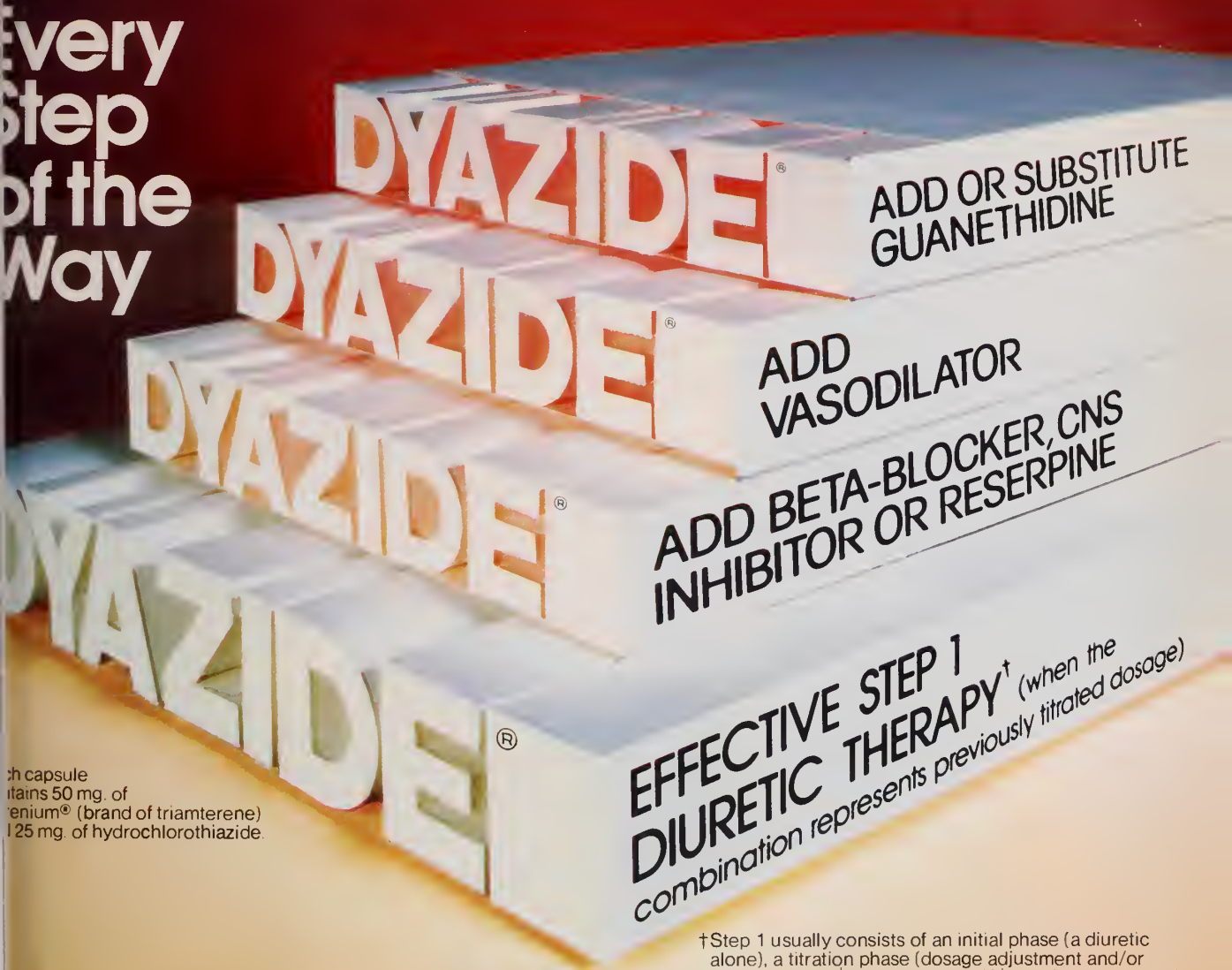

ch capsule
itains 50 mg. of
enium® (brand of triamterene)
l 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

ore prescribing, see complete prescribing rmation in SK&F Co. literature or *PDR*. A brief mary follows:

VARNING
his drug is not indicated for initial therapy of dema or hypertension. Edema or hypertension quires therapy titrated to the individual. If this ombination represents the dosage so determined, its use may be more convenient in patient anagement. Treatment of hypertension and dema is not static, but must be reevaluated as onditions in each patient warrant.

ntraindications: Further use in anuria, progres- renal or hepatic dysfunction, hyperkalemia existing elevated serum potassium. Hypersensi- to either component or other sulfonamide-ved drugs.

nings: Do not use potassium supplements, ary or otherwise, unless hypokalemia develops ietary intake of potassium is markedly impaired. upplementary potassium is needed, potassium ets should not be used. Hyperkalemia can occur, has been associated with cardiac irregularities more likely in the severely ill, with urine volume than one liter/day, the elderly and diabetics with ected or confirmed renal insufficiency. Period- y serum K^+ levels should be determined. If arkalemia develops, substitute a thiazide alone. rict K^+ intake. **Associated widened QRS com- or arrhythmia requires prompt additional apy.** Thiazides cross the placental barrier and ear in cord blood. Use in pregnancy requires ghing anticipated benefits against possible ards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently, both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only), in Patient-Pak™ unit-of-use bottles of 100.

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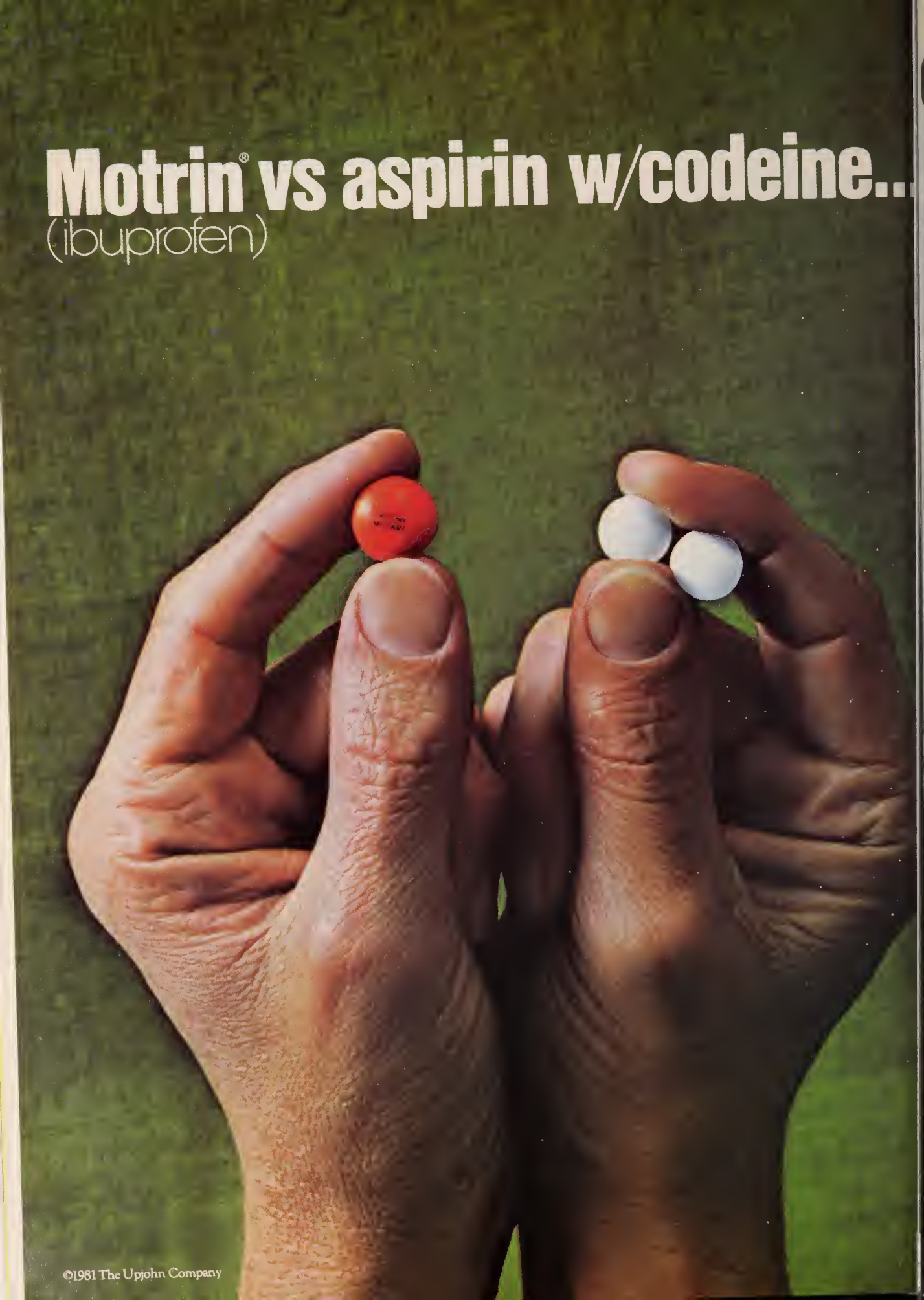
SK&F CO.
a SmithKline company
Carolina, P.R. 00630

Motrin® vs aspirin w/codeine...
(ibuprofen)



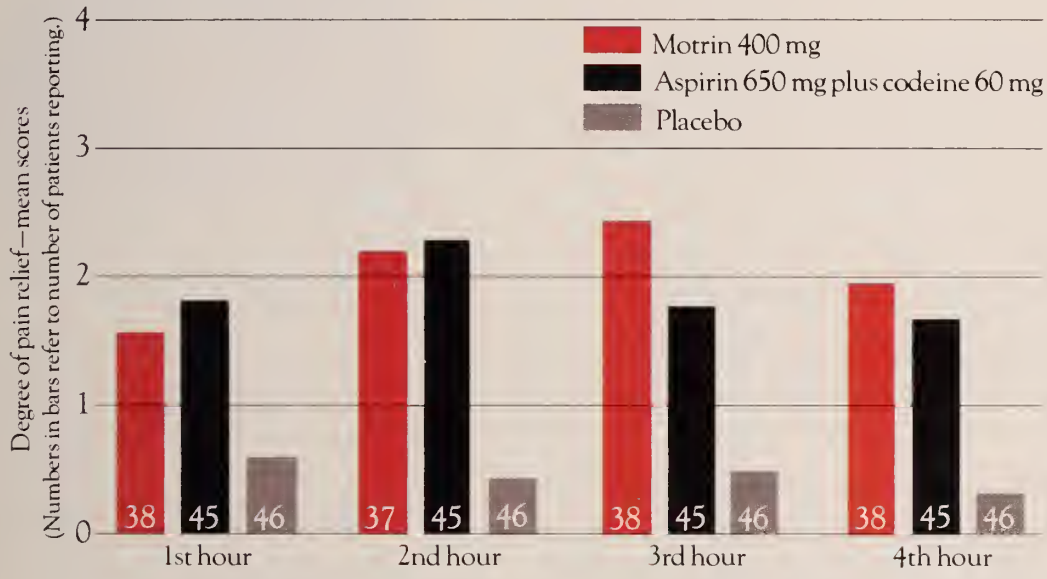
©1981 The Upjohn Company

compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



Time after drug administration (hours)

Data on file at The Upjohn Company.

One tablet q4-6h prn
For relief of mild to moderate pain:

Motrin® 400 mg TABLETS
ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea;* epigastric pain;* heartburn;* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness;* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

MED B-4-S

J-8260-4

MARCH 1981

WHY I'M A UNITED WAY VOLUNTEER

STEPHEN GRAHAM

Home: Seattle, Washington

Career: Attorney

Age: 29

Married: One daughter

Interests: Hiking, writing, cartooning, bicycling and volunteering for United Way

"Because there's more to my life than just me.

"Like being with my family. Hiking along the timberline. And getting involved in my community.

"Volunteering for United Way adds another dimension to my life. I'm putting my skills to work for the benefit of the entire community. And I'm meeting all kinds of people who are doing the same.

"Most important of all, I'm learning more about human care needs. And how—as a United Way volunteer—I can make a difference here in Seattle. It's a valuable lesson in leadership.

"By helping shape my community's future, through United Way, I'm more than just living my life. I'm fulfilling it."

Thanks to you... it works... for ALL OF US **United Way**

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WPS

report

for Wisconsin Physicians

Volume X, Number 1

April 1981

MEDICARE SECOND OPINION PROGRAM

The Department of Health and Human Services (HHS) has requested Medicare Carriers to assume a number of tasks related to Medicare program administration. Among these tasks is administration of the Medicare Second Opinion Program. Through this patient-initiated program, Medicare beneficiaries and others are encouraged to obtain another physician's opinion when **non-emergency surgery** is suggested by the patient's original physician.

Under the Second Opinion Program, payment may be provided for history, examination and other covered diagnostic services required for the physician to evaluate the patient's condition and render a professional opinion on surgical necessity. Reimbursement is based on the Medicare reasonable charge determination for consultations and related services, subject to the annual $60 deductible and 20% coinsurance provisions.

WPS has two major responsibilities under the Second Opinion Program. First, WPS prepares and updates a listing of all Wisconsin physicians who have expressed a willingness to participate in the program. Second, WPS provides the names of such physicians to persons requesting second opinions, with due regard to specialty and geographic location.

Currently, over 1,500 Wisconsin physicians participate in the Medicare Second Opinion Program by making themselves available for a second consultation.

WPS has attempted to publicize the availability of this program to physicians by directly contacting as many Wisconsin physicians as possible. Therefore, WPS requests that any physician wishing to participate complete the form on the reverse side of this page and mail to:

WPS-Medicare
P.O. Box 1787
Madison, WI 53701
Attn: CPCU

Once WPS has received the form, the physician's name will be automatically added to the list of participants. Please direct any questions about this program to the above address or phone (608) 221-4711 extension 420 and ask for Mrs. Johnson.

If you have any questions or comments on "Report," send them to WPS, Communications Division, 1717 West Broadway, P.O. Box 8190, Madison, WI 53708.

The Medicare Second Opinion Program (patient initiated) discussed on the reverse side should not be confused with the second opinion program recently adopted under Title 19 (Medical Assistance). Ten surgical procedures are included in the initial phase of the Title 19 program which began February 1, 1981. They are:

PROCEDURE	CPT-4
Cataract extraction	66840 66850 66920
Cholecystectomy	47600, 47605 & 47610
D & C, diagnostic	58120
Hemorrhoidectomy	46255 through 46262
Hernia, inguinal	49500 through 49525
Hysterectomy	58150 58260 through 58280
Joint replacement Hip	27130
Knee	27447
Tonsillectomy, adenoidectomy	42820 through 42826
T.U.R., Prostate	52601 52612 through 52614
Varicose vein surgery	37700 through 37731 37780 through 37781

Under the Medical Assistance Program the requirement for a second opinion applies to all physicians regardless of specialty. Surgery performed without a second opinion will not be reimbursed, and the second opinion physician may not perform the surgery.

Physicians who have any questions or who wish to participate in the **Medical Assistance Second Opinion Program** should call (608) 267-9474.

To: WPS Second Opinion Project Coordinator (CPCU)

PLEASE CHECK ALL APPROPRIATE BOXES

I am willing to participate in the second consultation program by:

A. ☐ Providing second consultations to Medicare beneficiaries.

I will ☐ will not ☐ accept assignment. (Acceptance of assignment is not a condition for participation in this program.)

B. ☐ Providing second consultations to Medicaid recipients.

I am certified for Medicaid _____Yes _____No.

C. ☐ Providing second consultations to non-Federal patients.

D. ☐ I do not wish to participate.

Name _____

Address _____

_____

I am affiliated with the _____ clinic, group or partnership.

Phone _____

My Specialty is: _____

I am Board Certified in this Specialty _____Yes _____No

Medical Yellow Pages

RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

Emergency Medicine. Directorship and clinical positions in low volume emergency department located in the northwestern portion of Wisconsin. Excellent income with additional compensation for director's responsibilities. Paid professional liability insurance, flexible scheduling without on-call involvement. For details contact Frank Siano toll-free at 1/800/325-3982, or send credentials in complete confidence to 970 Executive Parkway, St Louis, MO 63141. 4-6/81

Full Time Faculty Position—Assistant Director of the sixth and newest Family Practice Residency Program of The Medical College of Wisconsin. Potential to become associate director, dependent upon qualifications. Faculty appointment to the highly successful Department of Family Practice of The Medical College of Wisconsin. Opportunity to participate in the formulation of a new program; residents to begin training July 1981. Outstanding Family Practice Center facilities. Candidate must be Board certified or Board eligible in Family Practice. Located in Southeastern corner of Wisconsin; 45 minutes from Milwaukee; 60 minutes for Chicago. Faculty rank and salary are negotiable, dependent upon qualifications and experience. Many fringe benefits. Send curriculum vitae and references to: RG Burnett, MD, Program Director, Southeast Family Practice Residency Program of The Medical College of Wisconsin, Tallent Hall, University of Wisconsin-Parkside, PO Box 598, Kenosha, Wis 53141. The Medical College of Wisconsin is an Equal Opportunity/Affirmative Action Employer. p4-5/81

General Surgeon, Board certified or eligible to join 8-man, multispecialty group on shores of Lake Michigan in picturesque Northeastern Wisconsin. Excellent 89-bed hospital two blocks from modern clinic. Call coverage available. Position available now. Contact Robert E Myers, MD, Doctors Clinic, Ltd, 2219 Garfield St, Two Rivers, Wis 54241; phone 414/793-2281. 4-5/81

LaCrosse, Wisconsin. A progressive, 50-physician, multispecialty group, providing primary and secondary patient care, with a developed satellite system, is looking for physicians in the following specialties:

- General Surgery (with vascular interest)
- Ophthalmology
- Orthopedic Surgery
- Neurosurgery
- Physiatry

First year guaranteed income negotiable. Excellent corporate benefits in addition to qualified profit-sharing plan and support for continued medical education. 350-bed hospital affiliation. Ideal family oriented community of 50,000 with excellent schools, economy, culture and recreation for all four seasons. Send CV to: Director of Professional Affairs, Skemp-Grandview-LaCrosse Clinic, Ltd, 815 S 10th St, LaCrosse, Wis 54601. 4/81

Opportunity available in a community southwest of Eau Claire, Wisconsin. Financial assistance available to establish practice. Replacement hospital facility under construction. For details, send curriculum vitae, or call collect Recruitment Director, Adventist Health System North, 15 Salt Creek Lane, Hinsdale, Ill 60521; ph 312/920-1100. 3-4/81

Fifty-physician multispecialty clinic in West Central Wisconsin wants allergist, cardiologist (noninvasive), neonatologist, orthopedic surgeon, otolaryngologist, and family practitioner for nearby satellite office. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or phone 715/839-5266. 4-6/81

Family Physician to join two Board certified family physicians and one physician's assistant in a young and growing medical practice in Central Minnesota. The practice is oriented towards family medicine. The practice is located centrally in the state with quick access to Minneapolis/St Paul. Cultural and recreational activities are in abundance in this area of Minnesota. Salary open: Contact Daryl G Mathews, Admin, or Thomas J Newton, MD at the Cold Spring Medical Clinic, 26 N Red River Ave, Cold Spring, Minn 56320. Phone 612/685-8641. 4-6/81

California. Anesthesiologist wanted in Northern California fee-for-service practice located in Marysville. Area is within easy driving distance of Lake Tahoe, ski and recreation areas, Sacramento and the San Francisco Bay Area. Great year-round climate with still reasonably priced homes. Modern, progressive, well-equipped hospital with growing medical staff. Attractive relocation incentive. Contact Judy Neal, 440 Grand Ave, Suite 500, Oakland, Calif 94610. Phone 415/832-6500. 4/81

Dermatologist wanted to work in office located in downtown Milwaukee. Opportunity to take over practice in one year. Contact Leonard S Markson, MD, 161 W Wisconsin Ave, Milwaukee, Wis 53203. Phone: 414/271-9488. 4/81

Physician—University of Wisconsin-Stout: Seeking physician for the Student Health Center which offers outpatient care to 7,000 students. License or eligibility to practice in Wisconsin required. Position entails primary care and coordination of activities of the Center in cooperation with the Administrative Director. Beginning date—August 15, 1981. Salary negotiable. Liberal fringe benefits including malpractice insurance. Contact: Dr Joseph M Larkin, Associate Dean of Students, University of Wisconsin-Stout, 303 Administration Building, Menomonie, Wis 54751. Phone 715/232-1436. 4-5/81

Emergency Physician: Southeastern Wisconsin, begin July 1981. Flexible schedule and excellent salary are guaranteed. Send CV to: Associated E R Physicians, 1131 Sherwood Lane, Caledonia, Wis 53108; ph 414/835-4889. 3-5/81

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

8-12/80,1-7/81

Physicians Exchange

continued

Ideal Practice Opportunities for:

- Ophthalmologist
- Psychiatrist
- Neurologist
- Urologist
- Family Practice

Board eligible or board certified to join 49-man multispecialty practice in Southern Wisconsin, 45 minutes to Madison and 90 minutes to Milwaukee. Perfect location for good family living. Contact R E Hassler, MD, The Monroe Clinic, Monroe, WI 53566 or phone collect 608/328-7000. 4-6/81

General Surgeon and Orthopedic Surgeon. Both needed for 7-man multispecialty group in town of 10,000. Located 30 miles southwest of Milwaukee. Our facility is immediately adjacent to a 140-bed hospital. Position open immediately. Please contact Wayne Hansen, Burlington Medical Center Ltd, 190 Gardner Ave, Burlington, Wis 53105. Ph 414/763-9121. p3-5/81

Orthopedic Surgeon wanted to join orthopedic surgeon who has been in practice in Wisconsin Rapids since 1967. Excellent professional opportunity. Very competitive first-year salary and optional second-year corporate stockholder. Complete benefit package includes company-owned car. Call Tom Campbell collect at 414/255-6500 or send curriculum vitae to Orthopaedic Surgery Clinic of Wisconsin Rapids, 420 Dewey St, PO Box 1265, Wisconsin Rapids, Wis 54494. 4-5/81

Emergency Physician needed June-July 1981 to replace vacancy in five physician career oriented group at Madison, Wisconsin's largest emergency service. Great place to work and live. Send CV and will call you. John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 2tfn/81

Roth Young Personnel of Milwaukee
Health Care Placement Specialists

We provide a complete health care service from coast to coast for Physicians, Nurse Executives, CNS, Therapists, Technologists, etc. Through our interchange system we have available openings in the right location and setting for you! Call collect or send CV to:

Chuck Manning
Roth Young Personnel
PO Box 13527
Milwaukee, Wisconsin 53213
414/476-2280 3tfn/81*

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN

MEDICAL PROFESSIONAL PLACEMENTS

5222 Painted Post Drive
Madison, Wisconsin 53716
(608) 222-2927

Licensed Employment Agency 9tfn/79

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Wanted: Family or General practitioner who does obstetrics to join well-established medical group. Complete clinic facilities and full hospital privileges. Liberal educational and vacation time. Guaranteed salary and opportunity for early partnership. Contact R E Jensen, MD, Rose-Jensen-Sanan, 621 E Walnut St, Green Bay, Wis 54301. Phone: 414/437-4366. 2-4/81

General Surgeon, July 1981, to join the Wilkinson Clinic, SC, a multispecialty group of 16 physicians located in lake country between Milwaukee/Madison. Excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: David O Ulery, MD, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066. 414/567-4433. 2tfn/81

Opportunity for Neurologist. Board eligible or board certified neurologist to join 46-man multispecialty practice in Southern Wisconsin. Close to University Centers. Competitive income. Contact R E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566 or phone 608/328-7000. 4-5/81

Wanted. Board certified or eligible oncologist to practice in conjunction with an 8-member medical department in a 22-member multispecialty group. Present sub-specialties: gastroenterology and cardiology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Family Practice Physician sought for affluent small town with excellent social, retail, and educational resources. Easy access to year-round outdoor activities and to Chicago and Rockford for social and professional opportunities. For the family man with ambition for a successful practice.

Contact: Harvey Pettry, Administrator
Highland Hospital
1625 S State St
Belvidere, IL 61008
815/547-5441 3-5/81

Family Practice opportunities in outstanding Southern Minnesota group. The Albert Lea Clinic, PA, is interested in contacting physician candidates for city and small town branch practices. This group is a 16-man multispecialty group in the primary and secondary care fields. Top salary first year. Senior physician participation beginning at the end of the first year, an incentive income distribution plan. Low cost buy-in. Maximum profit-sharing plan. Top level insurance plan and full range of other benefits. New hospital in city. Albert Lea is an exceptional place to live and these are choice practices. Please contact B J Boss, Administrator, Albert Lea Clinic, PA, 1602 Fountain St, Albert Lea, Minn 56007. Phone 507/373-8251, personal phone 507/377-1406 or contact T F Thompson, MD, 507/373-8251, personal phone 507/373-0259. 4-5/81

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 23-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 2tfn/81

Relocation opportunities or initial practice in Fox Valley for general internists, family practitioners, and pediatricians. Support of other independent practitioners assured. Excellent schools, recreational area, as well as clinical facilities in JCAH approved hospital. PO Box 801, Neenah, Wis 54956.
p11-12/80, 1-4/81

Family Practitioners for Rural Practice. One, but preferably two, family practitioner needed to serve an area of approximately 8,000 in Central Wisconsin. Clinic affiliation or private practice available. Salary guarantee possible. Close to excellent 181-bed fully accredited hospital. Send CV or contact Anton Omernik, Chairman, Recruiting Committee, 46 County A, Rosholt, Wis 54473. Phone 715/677-4761. p4-6/81

Family Physician. Four-man family practice group seeking fifth to assume established practice. Northern Wisconsin community of 8,000 with primary service area of 50,000. Excellent outdoor recreation opportunities. 80-bed hospital with full-time emergency room coverage. Competitive salary and fringes. Contact: Marsh Clinic, SC, 610 W Green Bay St, Shawano, Wis 54166. Ph 715/526-3137. p3-5/81

Board certified or Eligible primary care internist and family practitioners for full-time positions in medical school and teaching hospital affiliated community ambulatory care centers. Appointees eligible for faculty appointments. Wisconsin licensure required. Positions available July 1981. Contact Kenneth E Smith, MD, Downtown Medical and Health Services, 2430 West Wisconsin Ave, Milwaukee, Wis 53233. Equal Opportunity Employer M/F/H. 1-4/81

FAMILY PRACTICE OR INTERNAL MEDICINE PRACTITIONER—Team Practice in Madison with Staff Model Health Maintenance Organization

Very attractive working environment, predictable hours, close to University of Wisconsin Medical Center. Physician staff compensation package includes excellent salary, pension program, and full benefit coverage. For more information, call *F Manalo, MD, at 608/257-9700,* or send vitae to: *GHC, One South Park St, Madison, Wis 53715.* 4-6/81

Opportunity for qualified physician in Internal Medicine in a two-man general internal medicine department in Southern Minnesota. The Albert Lea Clinic, PA, is a 16-man multispecialty group in primary and secondary care fields. Financial rewards are exceptional and practice challenges very attractive. Negotiated top salary first year. Senior physician participation beginning at the end of the first year and incentive income distribution plan. The clinic has a low cost buy-in with a maximum profit-sharing plan. There is a top-level insurance program, medical reimbursement program, and a full range of other benefits. A nearly new hospital in the city provides an exceptional place to work. This is a choice practice in an exceptional place to live. Please contact B J Boss, Administrator, Albert Lea Clinic, PA, 1602 Fountain St, Albert Lea, Minn 56007. Phone 507/373-8251. Personal phone 507/377-1406 or contact L E Shelhamer, Jr, MD, 507/373-8251 or personal phone 507/377-1530. 4-5/81

Family Practice. General Clinic—Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Hematology/Oncology
- Family Practice
- Otolaryngology

Beautiful new building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

FAMILY PRACTITIONERS

Seeking a board certified/eligible family practitioner to join family practitioner and general internist in a high quality growing practice in northcentral rural Wisconsin. Modern clinic building adjoined to community hospital. Call shared with two other physicians in a nearby community. Associate membership, then membership affiliation with a large multispecialty medical group 60 miles distant offering the full spectrum of consulting services and providing laboratory and administrative support and continuing medical education opportunities. Salary and fringe benefits excellent. Practice experience desirable but not mandatory. This is an excellent opportunity to exercise your talents in adult medicine, pediatrics and OB-GYN in a small community environment practicing with skilled colleagues while enjoying a reasonable call schedule, freedom from business administration, and the security of ready access to consulting specialists in all fields. Send curriculum vitae and the names of persons who can be contacted for reference to:

Frederic Wesbrook, MD
Marshfield Clinic
1000 North Oak
Marshfield, WI 54449 2-4/81

Physicians Exchange

continued

Fort Wayne, Indiana—Emergency Department Physicians. American Medical Services Association, Inc, a Kansas City based multiple hospital physician group, is seeking career oriented primary care and emergency care physicians who are:

1. Board eligible or certified
2. Show an affinity for the team concept of medical practice
3. Business oriented
4. Show professional maturity and judgment
5. Have a keen desire to succeed
6. Committed to CME

We are successful because we offer the unique package of salary and benefits in the healthcare industry. All of our physicians participate in the ownership of the company. If you feel qualified we are interested in you. Contact: Michael P Colucci, Vice-President of Marketing and Recruitment, American Medical Services Association, Inc, 4400 Broadway—Suite 306, Kansas City, Missouri 64111, 816/931-3040. 2-4/81

Locum Tenens work wanted. The more you know about choices, the easier it is to choose. That's why CompHealth, the oldest, largest locum tenens organization in the United States, can help make choices easier for you. Any specialty can be covered including FP, IM, Rad, Anes, and OB/GYN. With a large selection of reliable, qualified physicians to choose from, CompHealth provides physicians, hospitals, clinics and communities with dependable locum tenens coverage, allowing you to keep your practice covered without inconvenience or concern. Turn a difficult decision into an easy choice. Contact CompHealth, 175 West 200 South, Suite 2003, Salt Lake City, UT 84101; ph 801/532-1200. 3-5/81

Family Practice. Wanted a family practitioner to locate in new clinic building in Poynette, Wis. Located 30 miles from Madison, Wis. Poynette is a village of approximately 1000 with a service area of 7000 persons. Salary guaranteed. Contact John Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 10tfn/80

The Nicolet Clinic, SC, a young progressive 33 physician multispecialty group, has superb opportunities available for the practice of:

- Family Practice
- Thoracic Surgery

Ideal family oriented community in metropolitan area with excellent schools, economy, culture, and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued medical education. Contact in confidence Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Phone: 414/727-4244. 3-6/81

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

The Fond du Lac Clinic, SC, a multispecialty group of 26 physicians has an opportunity available for a fourth pediatrician. Negotiable salary with full benefits and full partnership available after one year. Contact Kirk A Veit, MD, Fond du Lac Clinic, SC, 80 Sheboygan St, Fond du Lac, Wis 54935. p2-4/81

Orthopedic surgeon wanted to join a primary care/specialty group of 11 physicians in northwestern Wisconsin. Attractive family/recreational area 45 minutes from Twin Cities. Minimum salary guaranteed first year. Contact Tom Halverson, Clinic Manager, St Croix Falls Clinic, Box 739, St Croix Falls, Wis 54024. Phone 715/483-3221. 8tfn/80

Medical Facilities

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital Building to be completed Feb 1, 1980. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Fond du Lac facility. Complete medical practice suite available. Suitable for group or solo practice. Many built-in features. X-ray and lab. Air conditioned with all services provided. Ideal location just one-half block from St Agnes Hospital. Inquire D Idzik 414/921-6800. 5tfn/78

FOR RENT office space Greater Milwaukee area. 750-1500 sq ft in prestigious 3-year-old medical building located on Northridge Lakes (7400 West Brown Deer Road) only minutes from Northridge. Opportunity for medical group, specialist, or satellite office. Will remodel to suit. Please call area code 414/354-1160. 12tfn/80

Ritter ENT Unit. Includes motorized chair, service unit with air and suction and cautery and air pump. Also sterilizer with cabinet available. Good condition. Reasonable. PO Box 325, Stevens Point, Wis 54481. Phone: 715/341-2020. 2tfn/81

Available immediately. Solo family practice opportunity. Good growth potential in Fitchburg, the most rapidly developing area in Madison. For details contact M Gordon, MD, 2934 Fish Hatchery Rd, Madison, Wis 53713. Phone 608/273-1055. p4-6/81

For Sale Reasonable: Instrument cabinet; medical cabinet; rectal table; office stool; metal office cabinet with steam sterilizer and Pelton Autoclave and cold ultra violet lamp, Fischer. Contact Dept 489 in care of the Journal. p4/81

Practice for sale. General surgery, northwest side Milwaukee, Wis. Write to Dept 490 in care of the Journal or call 414/258-7733. 4-5/81

Real Estate

For Sale. Chicago Gold Coast John Hancock condo. 3 blocks Northwestern Hospital and University; also easy access other universities and hospitals. Busses one-half block away; walk to Loop and financial district; excellent shopping, restaurants, etc. Many high caliber professional and corporate executive unit owners who demand the finest in condo living. Excellent in-town residence. Amenities included in assessment: large all-year indoor pool, saunas, exercise rooms, eliminates outside health club membership. Laundry rooms, bicycle rooms, own private storage locker on apartment floor. Access within building to garage, office complex, shops and bank. Main 44th floor Sky Lobby has commissary, private restaurant for unit owners and guests; receiving room, valet shop, and party room. Beautiful large one bedroom on 76th floor unobstructed view Lake Michigan; eat-in kitchen, 2 huge walk-in closets, linen closet; levelor blinds and sheer draw curtains, unusual parquet floors. Monthly assessment $174. Annual taxes below $800 for 1980. Price: $150,000. Private owner relocating. Call after 5 PM 312/664-4665. p4/81

Elkhart Lake—2 bedroom rental condo on beautiful Elkhart Lake, furnished, 2½ baths, tennis, golf, 2 miles from Road America. Available May-Oct, day, week, month. $350/week. D Opel, MD, 1330 N 5th St, Sheboygan, Wis 53081; ph 414/458-4522. p3-5/81

Vail Condo—two bedrooms, kitchen, living room, fireplace, beautiful view. $525.00/week. Ralph N Bloch, MD, 9950 West 80th Ave, Arvada, CO 80005. Phone: 303/425-0961 or 303/399-9076. p4/80

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1980 through Aug 31, 1981.

WISCONSIN

MAY 6-8, 1981: *4th Annual Cardiac Rehabilitation Symposium,* Red Carpet Inn, Milwaukee, Wis. Sponsored by University of Wisconsin-Extension, Continuing Medical Education; Mt Sinai Medical Center, Milwaukee, American Heart Association. Approved 21 hours AMA Category I, 2.1 University of Wisconsin continuing education units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

MAY 7, 1981: *Tenth Annual Madison General Hospital Medical Staff Spring Medical Symposium, Madison.* Focus on "Summer Medicine." AAFP prescribed and ACEP Category I applied for. Further information: Medical Staff Office, Madison General Hospital, 202 S Park St, Madison, WI 53715. Phone: 608/267-6103.

MAY 8, 1981: Second Annual Professional Institute, *Obesity,* sponsored by the Department of Psychiatry, Mount Sinai Medical Center, at Sheraton Mayfair Hotel, 2303 North Mayfair Rd, Milwaukee, Wis. Approved 6 credit hours of Category I of AMA-PRA. Info: Bella H Selan, MS, Mount Sinai Medical Center, Outpatient Psychiatry Clinic, 950 North 12th St, Milwaukee, Wis 53233.

MAY 8-9, 1981: Annual Scientific Program of the Wisconsin Chapter of the American Academy of Pediatrics, Pioneer Inn, Oshkosh. Info: Frank Stiles, MD, Program Chairman, The Monroe Clinic, Monroe, Wis 53566.

MAY 9, 1981: Thirteenth Annual Southeastern Wisconsin Cancer Conference, Pfister Hotel, Milwaukee. Approved 3 credit hours of Category 1 of AMA-PRA and AAFP. Info: American Cancer Society, 6401 W Capitol Dr, Milwaukee, Wis 53216. (See further details elsewhere in this section.)

MAY 15, 1981: Second Annual Professional Institute, *Late Life Care,* sponsored by the Department of Psychiatry, Mount Sinai Medical Center, at Sheraton Mayfair Hotel, 2303 North Mayfair Rd, Milwaukee, Wis. Approved 6 credit hours of Category I of AMA-PRA. Info: Bella H Selan, MS, Mount Sinai Medical Center, Outpatient Psychiatry Clinic, 950 North 12th St, Milwaukee, Wis 53233.

MAY 16-17, 1981: *Wisconsin Neurological Society* Spring Meeting, Holiday Inn Downtown, 200 Cedar St, Green Bay. Open to all physicians, no registration fee. Symposium on Peripheral Neuropathies and Plexopathies. Saturday speaker, Dr Jasper Daube, Professor of Neurology, Mayo Clinic. Info: Gastone G Celesia, MD, 2500 Overlook Terr, Madison, Wis 53705.

MAY 22-28, 1981: *Holistic Health: The Family Practice of the 80s,* sponsored by the American Holistic Medical Institute, at the University of Wisconsin-LaCrosse.

JUNE 4-6, 1981: *Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias,* The Performing Arts, Milwaukee. Approved 18 credit hours of Category I of PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

JUNE 11-12, 1981: *Neurological Intensive Care Symposium,* Wisconsin Center, Madison, Wis. Sponsored by Continuing Medical Education, University of Wisconsin-Extension, and Division of Neurological Surgery, School of Medicine, University of Wisconsin, Madison. Approved 17 hours AMA Category I; 1.7 continuing education units, University of Wisconsin-Extension. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

JUNE 25-27, 1981: Annual Meeting of the Wisconsin Academy of Family Physicians, Hyatt Regency Hotel, Milwaukee. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

JUNE 27-JULY 11, 1981: *Scandinavian Holiday,* sponsored by the State Medical Society of Wisconsin. Cost: $1,998, round trip Milwaukee or Madison to New York to Copenhagen with return from Stockholm via Northwest Orient Airlines. Reserve space for $150 and final payment due on April 15, 1981. Info: Dittmann Tours, Inc, PO Box 199, Northfield, MN 55057, or contact Lee Johnson, SMS, toll-free 1-800-362-9080.

AUGUST 2-7, 1981: *Perspectives in Anesthesiology,* Tucson Hospital Education Program, The Abbey on Lake Geneva, Fontana.

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ADMINISTRATIVE MEDICINE PROGRAM
will present a CME Category 1 credit course on

Communication of Health/Policy Information by Clinician Executives

Friday, May 29 and June 5, 7:00-9:00 pm
Saturday, May 30 and June 6, 9:00 am-12:00 noon and 1:00-4:00 pm
on UW-Madison Campus

Instructor: Jeffrey Kunz, MD, senior editor of *JAMA* in Chicago and UW-Madison Medical School alumnus.

Course will cover methods for establishing good relations with the news media, especially techniques for distributing and controlling publication of technical, controversial, clinician-executive's organization.

Info: Administrative Medicine Program, University of Wisconsin-Madison, 1225 Obervatory Dr, Madison, Wis 53706. Phone: 608/263-4889.

WISCONSIN continued

AUGUST 24-25, 1981: *Uses and Abuses of Antibiotics in Clinical Practice,* Heidel House Resort, Green Lake. Sponsored by Berlin Memorial Hospital. Info: Linda E Nevers, CME Coordinator, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, Wis 54923. Phone: 414/361-1313.

SEPTEMBER 18-20, 1981: Fall Meeting, Wisconsin Society of Anesthesiologists, Lake Lawn Lodge, Delavan.

MIDWEST

MAY 7-9, 1981 (Illinois): *Midwest Anesthesiology Conference* (MAC), The Illinois Society of Anesthesiologists, Chicago Marriott Hotel, Chicago. g4/81

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ADMINISTRATIVE MEDICINE PROGRAM

May 26-June 14, 1981/Six Annual InterSession, Madison, Wisconsin

Decision Analysis for Clinicians—Friday, May 29, 7-8 pm; Saturday, May 30, June 6 and 13, 8 am-1 pm; and Sunday, May 31, June 7 and 14, 9 am-12 noon. *Dennis Fryback, PhD,* Instructor. Major topics are: decision trees, probability assessment, probability revision, utility assessment, sensitivity analysis.

Communication of Health/Policy Information by Clinician Executives—Friday, May 29 and June 5, 7-9 pm; Saturday, May 30 and June 6, 9 am-12 noon, and 1-4 pm. *Jeffrey Kunz, MD,* Instructor. Methods for establishing good relations with the news media, especially techniques for distributing and controlling publication of technical, controversial, clinician-executive's organization.

Clinical Administration in Health Care System—May 26, 27, June 1, 2, 3, 8, 9, and 10, 8 am-12 noon, and 1-3 pm. *Joy Calkin, PhD,* Instructor. Analysis of health care systems in light of organizational and small group constructs applied to problems encountered by clinicians in leadership positions.

Quality of Care: Evaluation and Assurance—Friday, May 29, June 5 and 12, 6:30-9:30 pm; Saturday, May 30, June 6 and 13, 8:30 am-12 noon, 1:30-3:30 pm, and Sunday, May 31, June 7 and 14, 8:30 am-12 noon. *Jay Norden, MD, MPH,* Instructor. The course addresses the current and future role of Professional Standards Review Organizations (PSRO's).

June 15-August 7, 1981: Summer Session Offerings

Legal Issues in Health Care Administration—June 15, 17, 22, 24, 29, July 1, 6 and 8; 7-9 pm. *Burton Wagner, JD,* Instructor. Analysis of the legal system and its influence on the provision of health care.

Values in Medical Care and Education—July 13, 15, 17, 20, 22, 24, 27 and 29; 7-9 pm. *Don Detmer, MD,* Instructor. Examination of the values of the present healthcare system and society at large, the ideological roots of the American political and educational philosophy, and the Waltenschauung of contemporary health professionals.

The offerings are available either for credit, audit, and/or CME Category 1 credit for those with a health professional degree. Info: **Administrative Medicine Program, University of Wisconsin-Madison, 1225 Observatory Dr, Madison, Wis 53706. Phone: 608/263-4889.**

MAY 15, 1981 (Minnesota): *Stroke Update,* at United Hospitals of St Paul. Co-sponsored by the AAFP and United Hospitals. Approved 7 credit hours of Category I of AMA-PRA and AAFP. Registration is limited. Info: Ms Vicky Pence, secretary to Essam A Awad, MD, Program Director, United Hospitals, 333 N Smith Ave, St Paul, Minn 55102. Phone: 612/298-8295. p4/81

MAY 20-22, 1981 (Minnesota): Annual Meeting, Minnesota State Medical Association, at Minneapolis. Info: H W Brunn, Exec Vice-pres, 2221 University Ave SE, Suite 400, Minneapolis, MN 55414.

MAY 21-22, 1981 (Illinois): *Medical Determinations in Workers' Compensation,* sponsored by the American Society of Law & Medicine at Ambassador West Hotel, Chicago, Ill. Info: A Edward Doudera, JD, Executive Director, American Society of Law & Medicine, 520 Commonwealth Ave, Boston, MA 02215.

JUNE 4-6, 1981 (Illinois): *Panoramic View of Flexible Bronchoscopy Today,* Chicago, Ill. Sponsored by the American College of Chest Physicians with the Rush-Presbyterian-St Luke's Medical Center. Approved 16 credit hours of Category I of AMA-PRA. Info: Department of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068. 4-5/81

JULY 18, 1981 (Illinois): AMA one-day intensive course on improving English pronunciation for foreign physicians. Formal credit in CME. Info: Henry Mason, Division of Professional Relations, AMA, 535 N Dearborn St, Chicago, IL 60610. Registration fees: $130 AMA members; $170 nonmembers; and $80 residents.

OCTOBER 1-3, 1981 (Nebraska): Nebraska Medical Association Fall Session, Lincoln Hilton Hotel, Lincoln.

1981 AMA Seminar

Improving English Pronunciation for Foreign Medical Graduates

AMA Headquarters—535 N Dearborn St Chicago, Illinois (9:00 am-4:30 pm) Saturday, July 18, 1981

Course is designed to assist foreign physicians now in practice in the United States in improving spoken communications with their patients. Physicians attending will receive formal credits in continuing medical education.

Course will be taught by Mrs Elizabeth Lang, professor of English as a second language, Cuyahoga Community College, Cleveland, Ohio. Mrs Lang has developed a study manual and cassette tapes for home study.

There will be lectures and practice on producing the sounds of general American English, intensive oral drill and criticism of individual students, and practice in sustained discourse through reading and extemporaneous speaking.

Course is limited to 20 students. If it is oversubscribed by as many as 10, an additional course will be held on Sunday, July 19.

Registration fees: $130 for AMA members; $170 for nonmembers; and $80 for residents. (Includes nine practice tapes and 134-page manual.)

Further information on the course is available from Henry Mason, Division of Professional Relations, AMA, 535 N Dearborn St, Chicago, IL 60610. Course director is Mortimer Enright, head of the AMA's Speakers and Leadership Programs Section.

OTHERS

JULY 29-AUG 8, 1981 (Caribbean): Ten-day cruise, departs Ft Lauderdale on July 29 and stops at St Maarten, Antigua, Barbados, Martinique, and St Thomas. Approved 23 credit hours of Category I of AMA-PRA. Info: International Conferences, Suite C, 189 Lodge Ave, Huntington Station, NY 11746. Phone: 516/549-0869. (See ad elsewhere in this section.)

AUG 22-SEPT 5, 1981 (Mediterranean): Fourteen-day cruise, departs Venice, Italy, and visiting Egypt, Israel, Turkey, and Yugoslavia. Approved 23 credit hours of Category I of AMA-PRA. Info: International Conferences, Suite C, 189 Lodge Ave, Huntington Station, NY 11746. Phone: 516/549-0869. (See ad elsewhere in this section.)

OCTOBER 17-21, 1981 (Louisiana): Annual Meeting, American Society of Anesthesiologists, New Orleans. Info: ASA, 515 Busse Highway, Park Ridge, Illinois 60068 (ph 312/825-5586).

AMA

JUNE 7-11, 1981: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 6-9, 1981: Interim AMA House of Delegates, Las Vegas, Nev.

FEBRUARY 25-28, 1982: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill. ■

Ninth Annual Illinois Congress on Continuing Medical Education

September 11-12, 1981

Friday, Sept 11, 7:45 pm to Saturday, Sept 12, 5:00 pm

Oak Brook Hyatt Hotel, Spring & Harger Roads

Oak Brook, Illinois

How Physicians Learn: Effective Methods in CME

This year's Congress, sponsored by the Illinois Council on Continuing Medical Education is the second of a four-year program cycle presenting all the fundamentals of CME planning. The 1981 program focuses on effective learning methods as well as skill in selecting methods likely to achieve specific CME Program Goals and Learning Objectives.

Highlighting this year's program will be *Howard S Barrows, MD*, Associate Dean/Education Affairs, Southern Illinois University School of Medicine, known internationally for his work in *problem-solving* and *simulations* in medical education.

Most of the Congress consists of small-group workshops, such as: Matching Methods to Needs, Teaching with Technology, Self-Directed Learning Techniques, Do's and Don'ts of Didactics, Medical Audit as a Learning Method. There also will be a special workshop for non-physician CME Coordinators.

For additional information, write or call the **Illinois Council/CME, 55 E Monroe, Suite 3510, Chicago, Illinois 60603 (ph 312/236-6110).**

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"WATS" LINE FOR MEMBERS

As a new service for its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8 00 am and 4 30 pm weekdays The number to dial is

1-800-362-9080

AVAILABLE PHYSICIANS LISTED IN NEW VERSION OF AMA REGISTRY

For communities and institutions looking for the services of a physician, or for physicians looking for a new practice location, the February 1981 editions of the *Opportunity Placement Register* and the *Physician Placement Register* are available.

The American Medical Association's opportunity register lists openings for physicians, indexed by specialty, type of practice, location and size of community, date of availability and financial arrangements. The physician register contains the resumes of physicians wishing to relocate.

Copies of the books and further information on the AMA programs are available from the Physicians' Placement Service, American Medical Association, 535 N Dearborn St, Chicago, Ill 60610.

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

SUPREME COURT UPHOLDS PARENTAL NOTIFICATION FOR ABORTIONS. The US Supreme Court upheld a Utah state law, March 23, which requires a physician to notify the parents of a minor seeking an abortion. The case was brought by a 15-year-old Utah girl whose physician refused to perform the abortion she sought without first telling her parents. The girl argued that the law violated her right to privacy and interfered with the doctor-patient relationship. She also charged the law was unconstitutionally broad because it failed to exempt "mature" or "emancipated" minors. ("Emancipated" minors are those who are married, self-supporting, or in other ways independent of their parents. "Mature" minors are those whom the law regards as capable of making informed decisions about their health and welfare.) The court decision applied only to considering the constitutionality of the Utah law only as it applied to an "immature, dependent minor" like the defendent. Currently Wisconsin law, as a general rule, requires a physician to obtain *parental or guardian consent* before providing medical services to an unemancipated minor. Under appropriate circumstances a court may give consent in lieu of a parent. Wisconsin law also provides that a minor receive diagnosis of and treatment for venereal disease without parental consent. Attempts to expand this law to cover other specific fields of medical care (abortion, contraception, and drug abuse) have been unsuccessful.

EMTs MAY TREAT FOR SHOCK UNDER PHYSICIAN'S DIRECTION. A change in state law last year gives emergency medical technicians (EMTs) the authority to administer injections or other treatment for anaphylactic shock provided the EMT has completed a course on treatment of anaphylactic shock, and administers the treatment under the direction of a physician. Under Chapter 321, Laws of 1979, Section 1. 146.50 (9) (a), the State Department of Health and Social Services is required to make training courses on anaphylactic shock treatment available. It does not require EMTs to receive the training.

NEW REGULATION LIMITS USE OF DEXTROPROPOXYPHENE. The State Controlled Substances Board reminds physicians that the reclassification of dextropropoxyphene as a Schedule IV narcotic drug has affected its use with opiate-dependent persons. Under current Food and Drug Regulations methadone is the only drug authorized for "maintenance treatment" or "detoxification treatment" and therefore physicians may no longer use dextropropoxyphene for these purposes. Use of dextropropoxyphene for analgesia continues to be legitimate, including in opiate dependent persons, according to the Board. Physicians with questions may contact the State Controlled Substances Board Staff at 608/266-7586.

SMS LODGES STRONG PROTEST ON DECERTIFICATION RULES. SMS President Russell Lewis, in a letter to DHSS Secretary Percy, has seriously questioned the validity and appropriateness of proposed administrative rules for the operation of the State's decertification program and service specific rules for open heart surgery and cardiac catheterization. He urged a reconvening of a technical advisory committee to further consider the methodology of decertification. He charged that the proposed rules are a "gross error" and inconsistent with legislative intent saying, "I am concerned that Bureau of Needs Review staff is substituting its own value judgments for those of healthcare providers and patients in determining the medical needs of the community." SMS plans to oppose the rules all the way through the Legislature unless major changes are accomplished, which at this point, seem doubtful.

HOSPITAL LIABLE FOR PHYSICIAN MALPRACTICE, COURT RULES. The Wisconsin Supreme Court has ruled that a hospital was liable for malpractice by one of its staff physicians because it failed to make a reasonable effort to determine whether the physician was qualified to perform surgery before granting him surgical privileges. The court said that the hospital's failure to exercise the degree of care that is used by the average hospital in approving applicants constituted "negligence." ■

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WISCONSIN MEDICAL JOURNAL

MAY 1981

- President and President-elect's reports to House
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- Cardiovascular disease in Wisconsin
- Unified membership ends in Wisconsin
- Post-annual meeting reflections

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Additional information available to the profession on request.

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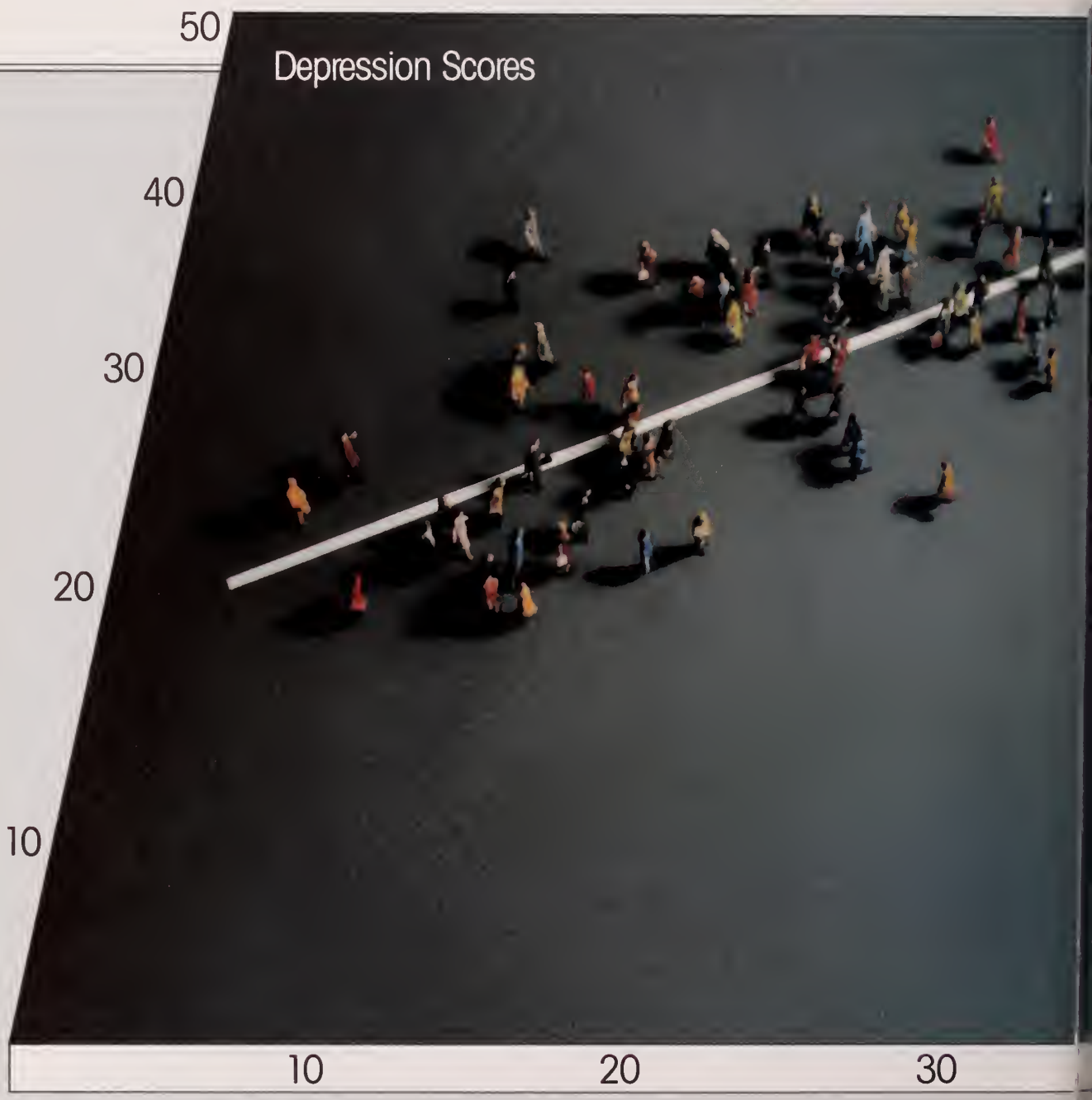

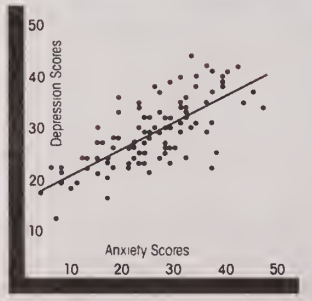

Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3]Adapted from Clogharn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

ROCHE®

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]

Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35*:1359-1365, 1978. **3.** Claghorn J: The anxiety-depression syndrome. *Psychosomatics 11*:438-441, 1970. **4.** The Task Force on Late Neuralagical Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137*:1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacalogy 61*:217-225, 1979.

Anxiety Scores

50

In moderate depression and anxiety

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Please see summary of product information on next page.

LIMBITROL® TABLETS Tranquilizer–Antidepressant
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Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses Myocardial infarction and stroke reported with use of this class of drugs) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives Concomitant use with other psychotropic drugs has not been evaluated sedative effects may be additive. Discontinue several days before surgery Limit concomitant administration of ECT to essential treatment See Warnings for precautions about pregnancy Limbitrol should not be taken during the nursing period. Not recommended in children under 12
In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns
Anticholinergic. Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling
Overdosage: Immediately hospitalize patient suspected of having taken an overdose Treatment is symptomatic and supportive. I.V administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime Single *h.s* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol 5-12 5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.
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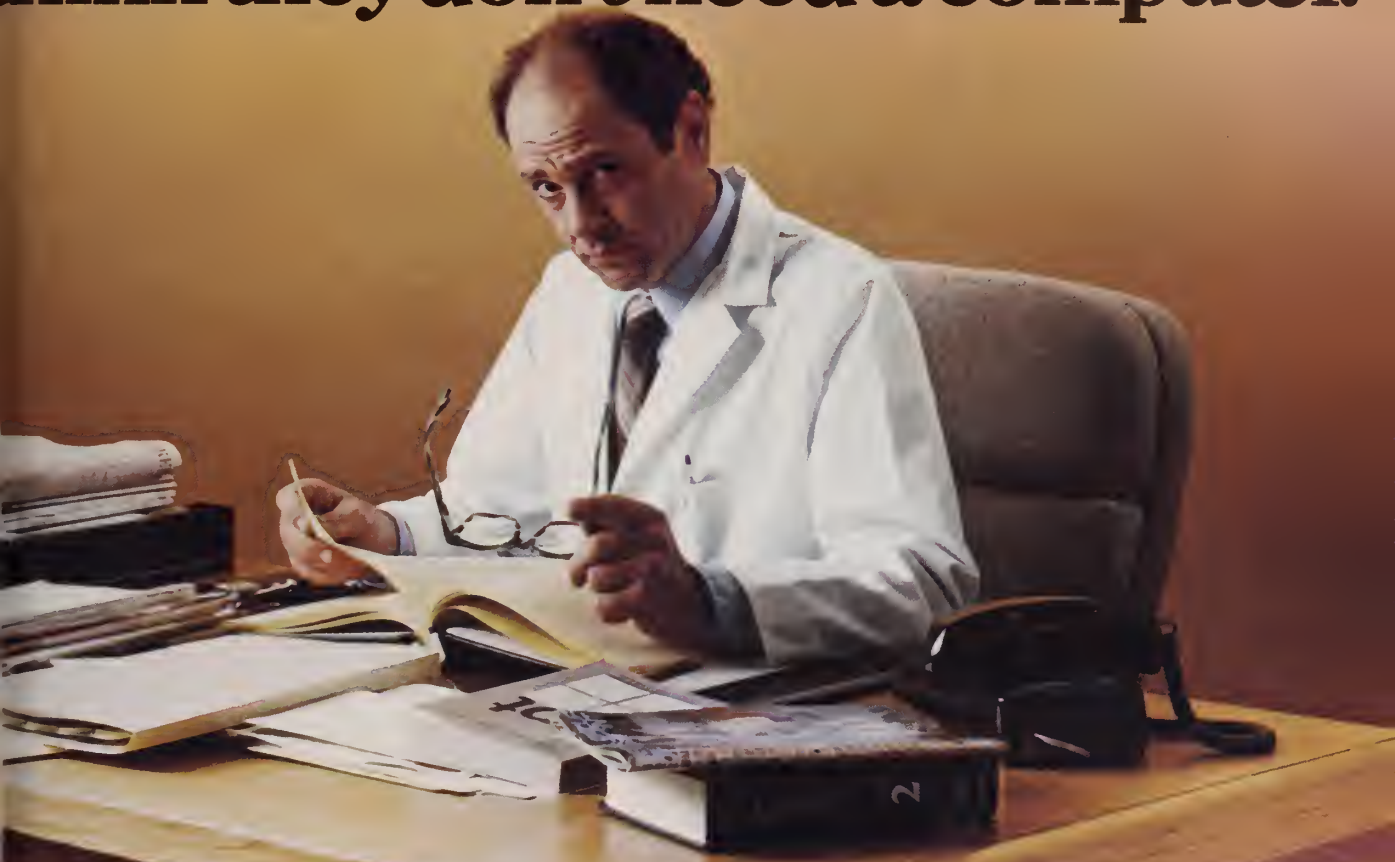

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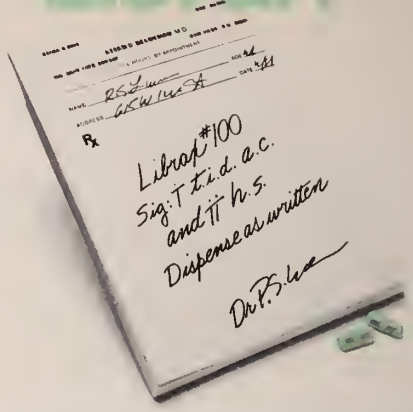

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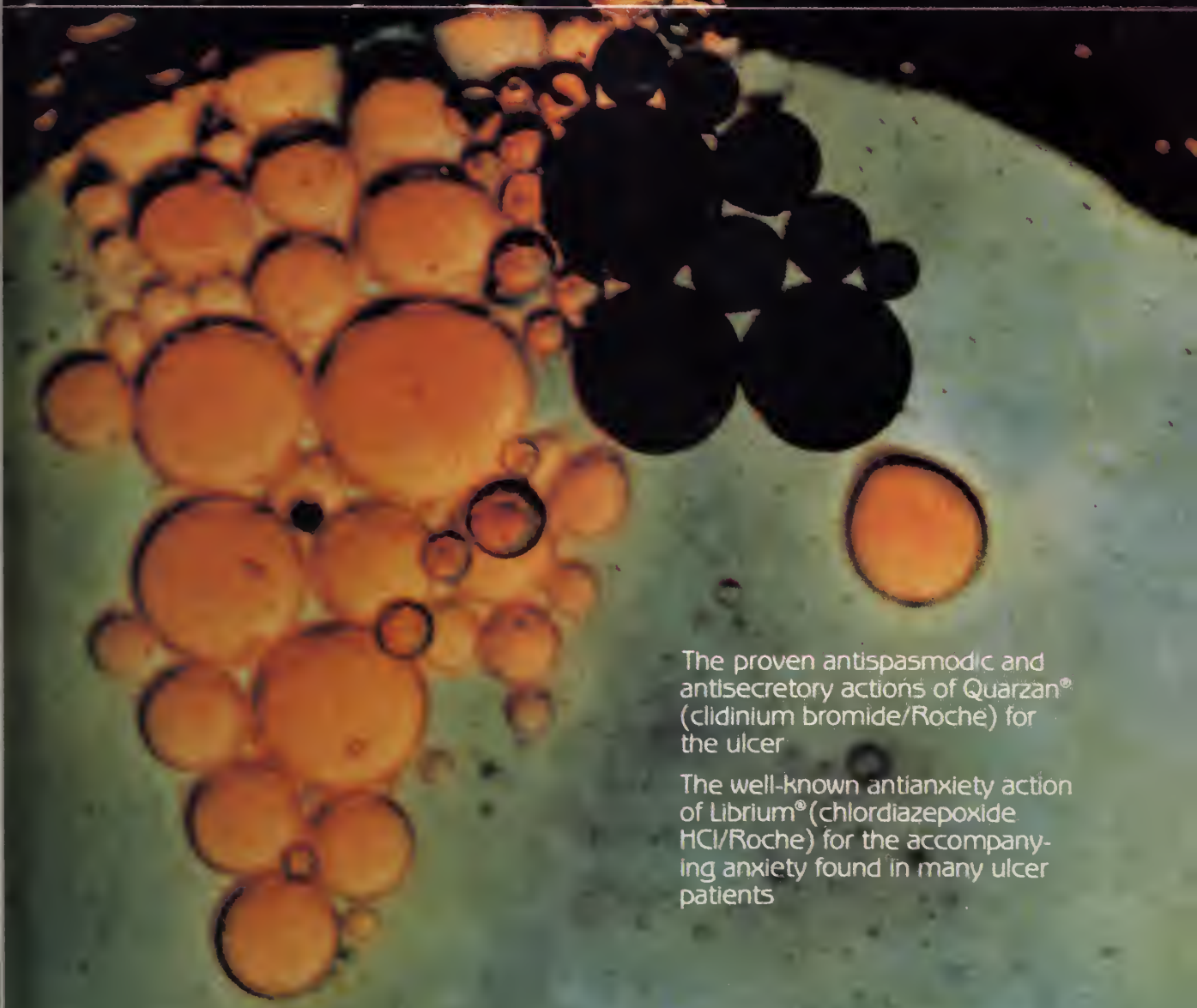

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Generous reduction and rebate

A FEW YEARS AGO many Wisconsin physicians were caught in a real malpractice insurance bind. Fortunately, the State Medical Society worked closely with the state Legislature and created WHCLIP.

The Board of Governors of WHCLIP has recently announced a 47.1% rate decrease effective July 1. This is the third decrease in three years. In addition, there will be a 30% premium adjustment for the current year's coverage which will result in a rebate.

Physicians are being solicited to invest in a competing liability insurance company. If this organization gets off the ground, there will be further solicitations to subscribe for policies with the new company. If this comes to pass, don't forget who went to bat for you a few years ago and who has established such an excellent record since that time. The officers and staff who were responsible for influencing the creation of WHCLIP are to be congratulated and thanked. Continued participation in this program would be an expression of our gratitude.—VSF

ADDENDUM: Count your blessings

The news out of New York is quite different. There the physician-owned medical malpractice insurance company has filed for a 71% rate increase to become effective July 1, 1981. This would mean the average New York physician's premium would be $14,500. Some specialists in particularly vulnerable areas would pay annual premiums up to $45,000 for obstetrician-gynecologists and $49,500 for orthopedic surgeons and neurosurgeons.

Wisconsin physicians, count your blessings! —VSF

Bring back the autopsy

A TRADITIONAL standard of excellence in the judging of hospitals has been the autopsy rate. Years ago, a rate of less than 50 percent was a matter of concern. Nowadays, however, few hospitals achieve a rate of 50 percent, and the number grows smaller every year.

It would be easy to blame the hospitals themselves and write off the autopsy as a victim of the frenzy to cut costs. After all, autopsies are expensive to perform, costing the hospital somewhere between $750 to $1000 each. But if you ask chairmen of pathology departments about it, they will tell you that they too are concerned about the trend and deny that they have done anything to discourage obtaining autopsy permits.

Why then the infrequency of autopsies in hospitals? Has the public changed its attitude and become less interested in getting at the final truth? That would be unlikely in view of their great and constantly growing thirst for knowledge of all things medical. Certainly they ask more questions now than they did 20 years ago.

If the hospital's attitude hasn't changed, and if the public hasn't lost interest, one would have to conclude that much of the fault lies with the physician. Obtaining an autopsy permit from a bereaved next-of-kin has always been a chore, but certainly it is no harder now than before. I can remember an older colleague who had a phenomenal success rate in securing autopsies, but he worked at it, even to the point of calling on the family at home, blank permission form in hand, to argue his case.

There is still much to be learned from the autopsy. Attending one performed on a patient of yours who failed to respond to your best efforts is often a humbling and always an educational experience, one that will be remembered far longer than a case report read in a journal. And it will provide more information than even the most sophisticated second or third generation CT scan. Let's see what we can do to bring the autopsy back where it belongs.—WJB

Unhelmeted kidney donors

TRAFFIC STATISTICS show an increase in mortality since it became optional whether motorcycle riders wore helmets. Those of us who are associated with emergency rooms are certainly familiar with the bleak prognosis of motorcycle riders brought in after a cycling accident with head injury when no helmet was worn.

The economic costs of head injuries to the community are considerable especially when many of the cyclists are young men who then need extensive care for which they are often insufficiently insured or uninsured. Some method for recouping some of the economic loss is in order.

Would it be possible to require that motorcyclists who wish to operate a motorcycle without a helmet

sign the uniform donor card for kidney harvest? If it were a requirement for unhelmeted motorcycle riders to donate their kidneys to the Kidney Foundation for transplant in the event of death, perhaps some of the economic loss could be recovered.

No doubt this would be a discriminatory law against the macho bike riders who wish to charge about unhelmeted, but certainly it would be a gesture to recover some of the tremendous and unnecessary losses due to the fatalities among motorcyclists. Think of all those dialysis patients waiting for kidneys. Each unhelmeted motorcyclist who dies could supply two kidneys.—RAM

There, but for the grace of God—

A DISTURBING NEWS item on medical liability was recently reported from Massachusetts. A woman sued and won almost $400,000 from her physicians because they failed to diagnose her breast cancer when it might still have been in a potentially curable stage. Aspiration of a cyst and subsequent follow-up examinations led to delays; and when operation was attempted several months later, the cancer was inoperable.

Without attempting to assess the professional skills and judgment of the physicians in this instance, one can only remark: "There, but for the grace of God go I."

Who among us hasn't put off breast biopsy following successful aspiration of a cystic lesion? This simple maneuver has obviated the need for countless breast explorations and has meant the saving of a great deal of money. Will we be able to continue to do this if the courts find against the doctor in cases where the aspiration technique causes delay in cancer diagnosis? I think not. We all will have to rush to the operating room and whip out every lump no matter how benign-appearing it may be. And that in the long run will do more harm than good.—WJB

For the Class of '81

GRADUATING CLASSES from the various medical schools are soon to be turned loose to begin their hospital practices—my own son among them. This is for them.

Last March, at a Milwaukee hospital, an imposter was finally apprehended after the second visit in which he had gained access to a female patient's room where he attempted to perform a rather "delicate" examination. His modus operandi consisted simply of introducing himself as a consultant and requesting permission to examine the patient. The first patient, although hesitant, acquiesced. The second patient (the next day) became suspicious and resisted, reporting the incident to hospital authorities leading to the arrest of the "consultant" as he headed for the exits.

What is the message in this? After all, this sort of thing happens from time to time, and is usually reported as an amusing curiosity. As I see it, the message is that in spite of all we hear to the contrary, doctors are still something pretty special in the eyes of the public. They will allow us privileges in spite of their misgivings because of their respect for doctors, and some of them admire us to the extent that they will risk all to experience vicariously for a few moments the status we are accorded every day in our practices, just to be called "doctor." You now possess that title. Wear it with honor. —WJB

Funny papers

YEARS AGO THE funny papers consisted of comic strips such as Happy Hooligan, Major Hoople, and Andy Gump who is immortalized by a statue at Lake Geneva. Now, we have unfunny strips such as Rex Morgan, MD whose current problem is MS and Mary Worth who is doling out motherly advice year after year.

There has been a revival of Orphan Annie who is ward of Oliver Warbucks, the bald millionaire who made his fortune in munitions in World War I. A recent episode exposed a Communist agent who was posing as an MD. He had impeccable credentials from the AMA but was tripped up when he was unable to give the Dow Jones closing level for the preceding day. What a splendid image for the medical profession!

Now Daddy Warbucks is investigating Medicare fraud with a cast of characters with such names as Doctor Sue Chures and Doctor E Lixer. The doctors who are perpetrating the fraud are naturally depicted as very obnoxious, overstuffed, and overpaid individuals.

No doubt there are some frauds in medicine as there are in every profession and occupation. Unfortunately, widely read strips of this sort tend to smear a lot of honest professionals with a bad brush. —VSF ■

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

A matter of semantics

AT THE RISK of being misinterpreted I would like to take issue with the article, "The hassle factor," by Brian H Jensen in the March issue of the *Wisconsin Medical Journal.*

I will not argue with the concept that the 1977 legislation should be repealed or modified. However, the opposition should be to "health regulation" by legislation and not to the concept of local health *planning.*

The opportunity to utilize the consumer-professional-governmental forums at the regional level is vitally important for the health system in these times of budget cuts and probable deregulation. Communications among the myriad facets of the health system is basic to avoid a swing to total controls in three or four years through such mechanisms as wage/price controls.

Many HSA programs to establish rational community goals and provide assistance in planning have saved resources and been cost-effective. The fedderal mandate for cost containment has not been as effective as the Congress proposed.

Semantics can be destructive. Let us alter, repeal or whatever, the regulation legislation, but we must promote communication and appropriate goals through regional consumer-professional-governmental networks as they are used as public forums.

George H Handy, MD
Madison, Wisconsin

Editor's note: Doctor Handy formerly was the State Health Officer; he currently is vice president and medical director of Cuna Mutual Insurance Group in Madison.

Itinerant surgery

IN THE MARCH 1981 issue of the *Wisconsin Medical Journal* editorial comments were made relative to itinerant surgery. The comments made by Doctor Boulanger all seem appropriate and nonargumentative to a point.

Much surgery is still done and done competently by local attending physicians and itinerant surgeons certified in their specialties in small community hospitals of less than 100 beds in this country. WisPRO statistics garnered through areawide audits suggest that the care these patients receive, in terms of complication rate and outcome, is at least equal to or, in some instances, better than that received in larger tertiary care centers. Postoperative care delegated to a family practitioner cannot categorically be called fee-splitting. The itinerant surgeon can decrease his fee to the extent that he is not directly managing the postoperative care, allowing for an attending physician to bill for this service. Total cost to the patient or the third-party pay system is not thereby increased over and above a usual and customary fee for a specific procedure.

Surgery performed in the community hospital promotes and allows easier visitation by friends and family than at a referral hospital 40 and more miles distant.

In many situations the attending physician, being familiar with his own patient, can prevent postoperative complications occasionally seen at tertiary care centers. For example, one of my patients recently had surgery performed at a tertiary care center and developed acute congestive heart failure when the medical staff failed to reinstitute digitalis and diuretic therapy postoperatively.

The general tone of the editorial was to present only one side of the picture of itinerant surgery and failed to be at all responsive to, or sympathetic to, the needs and problems encountered in delivery of rural healthcare.

Robert L Keener, MD
Antigo, Wisconsin

Breast cancer

WE REVIEW WITH interest Doctor Matallana's article[1] published in the March 1981 journal regarding the complementary diagnostic procedures in occult breast cancer. In that article we are referenced as objecting to mammography, breast ultrasound, galactography, pneumocystography, needle localization, and specimen radiography. We respectfully request that Doctor Matallana reread our critique in December 1979.[2]

The case report is an interesting one and one that is commonly seen in which the patient presents with one problem and through mammography is discovered to have yet another. The palpable cyst is nicely outlined in the one projection printed, as is the minimal carcinoma adjacent to it. What we feel is superfluous is the multiple documentation of an obvious lesion. Aspiration alone would have been sufficient proof that the lesion was cystic, and there would have been no need for a pneumocystogram or ultrasound. In these days of cost containment, is such duplication of diagnostic maneuvers justified?

As for needle localization and specimen radiography, we feel that this is an important approach toward minimal carcinoma of the breast. We reported our initial series in 1979,[3] and we are subsequently in the process of updating this which will be presented in Boston in May. Suffice it to say, since we have started breast biopsy with needle localization with or without specimen radiography about three years ago, we have biopsied approximately 100 women with roughly 20% of these being early carcinomas.

We congratulate Doctor Matallana for his nice demonstrations of radiographic technique, but our criticisms of December 1979 are still valid.

James L Hoehn, MD
Gail H Williams, MD
Jerry M Hardacre, MD
Department of General Surgery
Marshfield Clinic
Marshfield, Wisconsin

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Three cheers!

THREE CHEERS for you (VSF) and your editorial "Drugs with honors" in the February issue of the *Wisconsin Medical Journal.* Lennon and his cohorts were probably responsible for thousands of deaths. And their music was *zero.* "Ten minutes of silence" in mourning! Who stood even one minute for my dear friend, Dr Michael Halberstam! No comparison. You are right. "What fools we mortals be."

Ten years ago I challenged Margaret Mead at a lecture. She said only one marihuana user in a 1000 went on to heroin. But in NY State at the time there were 1,000,000 marihuana users (that made 1000 heroin users, at least). The audience booed me, but she was really non-plussed by the meaning of her own statistics. She had said, "I wish I was 16 again, I would smoke marihuana." God rest her soul and forgive her for that stupidity.

In the Talmud, our Jewish exposition of the Bible, it says that when the moral tone of the community is low, it is time to bend over backwards with stricter demands on the morals and social graces. This is certainly the time now.

Right on, Doctor Falk.

Nathaniel J Pulver, MD
Madison, Wisconsin

* * *

I WAS SORRY to read in the *Wisconsin Medical Journal* your editorial on the assassinated Lennon. Said item (Drugs with honors, *WMJ,* February 1981) should have received *national* distribution.

Raymond R Watson, MD
Huntington, West Virginia

Editor's note: Doctor Watson formerly practiced in Milwaukee. In 1979 he left his private practice to take a training program with the Veterans Administration (an equivalent of a residency program). He has completed the training program and as of this year has accepted an appointment as Associate Dean and Professor of Surgery at the new medical school called Marshall University School of Medicine, Huntington, West Virginia. ■

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Clinical preceptorship: The capstone of the University of Wisconsin-Madison Physician Assistant Education

Patrick C Runde, PhD, Madison, Wisconsin

THE HISTORY OF THE Physician Assistant Program at the University of Wisconsin-Madison reveals that it is only seven years ago that the Legislature of the State of Wisconsin directed the University to establish a Physician Assistant Program. The Program is one of the components of a new School of Allied Health Professions, and it was the hope of the Legislature that the University could graduate its first class of students by 1978. On May 29, 1977, a year earlier than anticipated, the University conferred the Baccalaureate Degree on its first class of Physician Assistants. Since that time, four additional classes have graduated from the Program. This brings to a total of 116 the number of men and women educated to assist physicians in Wisconsin and throughout the United States in the delivery of medical services.

The curriculum that was designed and approved by the faculty of the School of Allied Health Professions, the University, and finally by the Board of Regents represents a unique partnership bringing together the resources of the University and its Medical School with practicing physicians (preceptors) throughout the state. The curriculum was reviewed by the Council on Physician Assistants and was recommended for approval to the State Medical Examining Board. Preliminary approval was obtained from the American Medical Association and when the first class was graduated in 1977, final approval was awarded to the Program by the American Medical Association Council on Medical Education. The Program has enjoyed continued accreditation since that time.

To understand the curriculum that was established, it is perhaps best to first discuss that section of the curriculum that provides for the clinical education of the students. A major goal of the Program was to design a curriculum that would allow these students to have the opportunity to learn clinical medicine from Wisconsin physicians in settings that were representative of the practices throughout the state. To accomplish this the Program turned to the preceptorship model of the University of Wisconsin-Madison Medical School for guidance. A review of that model, which has had such an excellent tradition in the state, revealed that it had potential for the training of physician assistants. For this reason it was decided that the primary source for the students' clinical education would be the practicing physicians throughout the state of Wisconsin. To accomplish this the curriculum included a senior preceptorship year (32 credits) which provides the opportunities for students to rotate among selected practicing physicians throughout the state to obtain their clinical education. The focus of the preparation is in primary care and students must spend two of the four rotations in family practice or general internal medicine settings. The balance of their time can be spent in additional primary care settings or in specialty areas.

A request went out to the physicians in the state to assist in this important area of instruction. The response was gratifying and physicians from across the state have assisted in this important phase of education. Currently there are physician/preceptors in the following cities: Milwaukee, Burlington, Madison, Stevens Point, Monroe, Eagle River, Stoughton, Tomah, Phelps, Merrill, Fond du Lac, Middleton, Keshena, Mercer, Green Bay, Mukwonago, Darlington, Manitowoc, Oconto Falls, Woodruff, Berlin, Bowler, and Mondovi. Some of these preceptors have been with the Program since its inception, while others have joined within the past year. Some of these preceptors make use of other personnel—physician colleagues, emergency room personnel, physician assistants—in training the physician assistant students. The Program encourages this and is particularly pleased to have physician assistants in these practices serve as role models. The Program is continually soliciting additional preceptorships for the students in order to continue to provide them with the broadest possible overview of the practice of medicine in Wisconsin.

Prior to this senior year preceptorship, the students spend twelve months in intensive didactic instruction in the following courses: Anatomy; Health History and Physical Assessment; Pathology; Phar-

Doctor Runde is Associate Dean for Academic Affairs, School of Allied Health Professions, and Acting Program Chairman, Physician Assistant Program, University of Wisconsin-Madison. Reprint requests to: Patrick C Runde, PhD, Room 220 WARF Bldg, 610 North Walnut St, Madison, WI 53706 (ph 608/263-6800). Copyright 1981 by the State Medical Society of Wisconsin.

macology; Clinical Medicine I, II, and III; The Role of the Physician Assistant; Introduction to Basic Emergency Care; Advanced Emergency Care; Infectious Diseases; Advanced Patient Assessment; Laboratory Procedures; Obstetrics and Gynecology; Clinical and Therapeutic Nutrition; Preclinical Clerkship; and Introduction to Surgery. These courses amount to approximately 18 credits per semester plus an eight-credit summer session between the junior and senior year. The majority of instruction is through the faculty of the Medical School.

As a preparation for entering into the professional curriculum, students have a minimum of two years of preprofessional education. This includes education in basic liberal arts and sciences to give the students an opportunity, both through course work and through health care work experience, to develop a clear career concept of this new profession. While enrollment at the professional level is limited to 25 students per year, enrollment in the preprofessional years is not limited. During these years, the students carry an array of courses that focus on the basic sciences as well as courses in the humanities and the social studies. This permits students to complete many of the course prerequisites at other two- or four-year accredited schools throughout the state.

What kind of students are admitted into the Physician Assistant Program? A review of the applications over the last several years indicates that these students are in some ways not typical of the traditional college student. For example, they tend to be older. The average age of students when they are accepted into the professional part of the Program (junior year) is 25. Many of these applicants already possess an undergraduate degree, and some come to the Program with a graduate degree. The typical college student entering junior year has approximately 50-60 credits of work achieved, while students seeking admission into the Physician Assistant Program at the junior year typically offer an average of approximately 100 credits of work already accomplished.

The previous academic achievement of these students tends to be significantly above the average for students at the University. All students are required to offer some experience in a health care related activity. The previous health care experiences that these students offer are quite varied. In addition, letters of recommendation and an interview are required for admission. About 25% of the students in each entering class are married and the classes enroll approximately an equal number of male and female students. The great majority of students come from Wisconsin with only about 10% being from out-of-state.

Where are the graduates practicing? Most are in Wisconsin. In fact, 70% of the graduates have positions with physicians within Wisconsin. Some of these are with their physician/preceptor. Most are practicing in the smaller, rural communities. The effect on these students of working with physician/preceptors is encouraging, since the retention of our graduates in Wisconsin was always of paramount importance.

What were some of the objectives that were taken into account when the Physician Assistant Baccalaureate Degree Program was established? Among the underlying considerations that were paramount in the establishment of the curriculum were the following: (1) the Program was to conform to the AMA concept of the Physician Assistant so that it could be fully accredited by that body; (2) the intent of the Legislature, as expressed in Chapter 149 of the Laws of 1973, was to be carried out both philosophically and practically; (3) that the curriculum could accommodate a population of students, not on the Madison campus, in such a way that they could begin to meet the requirements of the freshman and sophomore year at other two- or four-year schools throughout the state; (4) that the curriculum would accommodate those students who are "nontraditional"; *ie,* those who have already received substantial instruction in another field or who had already obtained degrees previously; (5) that the curriculum would make greatest use of existing resources within the University, particularly within the schools comprising the Center for Health Sciences, so as to minimize expense and maximize interaction among the students in the Program with those in the other professions most particularly medicine, pharmacy, and nursing. Each objective has been met.

The faculty of the Program continually reviews the curriculum to be certain that it meets the above requirements. It is the belief among the faculty that while stability within a curriculum is desirable, too much stability has the potential to result in a stagnated and ineffectual program. With this in mind, the faculty reviews the goal and objectives of the curriculum to see where it can be improved in order to provide the best possible medical education for these physician assistant students. It is most important that the skills and attitudes developed by the students are reflective of the practice of medicine in the state of Wisconsin.

The commitment of the Legislature, and the citizens of the state, to this program has been evident since its inception. The Physician Assistant Program at the University of Wisconsin-Madison is one of the very few state-funded programs in the United States. For those involved in the establishment and maintenance of this Baccalaureate Program, this stable financial support is reassuring for it provides the stability so essential to plan for the future.

It would be remiss not to mention that the Program has recently been awarded a federal grant to assist it in carrying out its responsibilities for the preceptorship portion of the Program. This three-year grant provides support for salary and for the costs associated with working with the preceptors in the cities, towns, and villages of the state of Wisconsin. The Program hopes to develop even closer ties to these clinicians who serve so generously.

One can rightly ask the question: "Is the program successful?" If that question is answered from the standpoint of the practice locations of the Program graduates, one must answer: "It seems that it is."

Looking at success from another criterion—student achievement, it again appears that the curriculum is accomplishing its goals. The students regularly score well on the National Certifying Examination for Primary Care Physician Assistants, the examination prepared by the National Board of Medical Examiners. The results of the 1978 Certifying Examination were most gratifying since the UW-Madison Program graduates scored well enough to place the Program in second place among the 50+ programs represented. In all years the Program has had a pass-rate of 93.3% or better for those taking the exams.

With the continued generous support of physicians and physician assistants of Wisconsin, the faculty and staff of the Program will strive to maintain these records of accomplishment.

Persons desiring further information about participating in the training of PAs, employing a PA, or about the PA concept in general should contact: The Wisconsin Academy of Physician's Assistants, PO Box 1109, Madison, Wisconsin 53701. Executive Secretary: Bill Wendle, telephone 608/257-6781 or 800/362-9080. ■

May 1981 is National High Blood Pressure Month

The United States Department of Health and Human Services is reminding all Americans that there are 60 million Americans who have high blood pressure or hypertension and don't even know it. High blood pressure is symptomless, and today, it is one of the leading causes of death and disability in America.

May 1981 has been declared National High Blood Pressure Month. The goal of this year's public awareness program is to inform and educate all Americans about high blood pressure, a disease that causes more than 853,000 deaths from cardiovascular problems annually.

The disease is generally easy to diagnose, and the US DHHS is encouraging all Americans to have their blood pressure checked.

Further information about hypertension and National High Blood Pressure Month can be obtained from the High Blood Pressure Information Center, 120/80 National Institutes of Health, Bethesda, Md 20205.

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Cardiovascular disease in Wisconsin: Declining mortality and contributing factors

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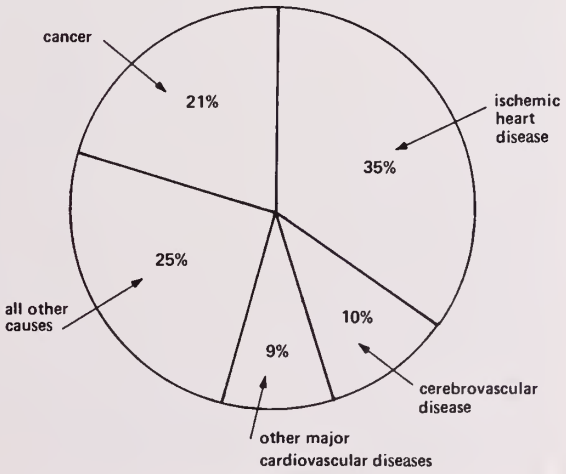
CARDIOVASCULAR DISEASE is the leading cause of death in Wisconsin and the United States. The following paper describes mortality trends for heart disease and stroke during the past three decades and outlines possible factors responsible for their recent decline. A comparison is also made between Wisconsin and United States mortality rates for major cardiovascular diseases and several subcategories. Surgical and medical advances as well as modifications of personal health patterns and life-style have all had an impact on cardiovascular health. The paper includes a discussion of how these factors have contributed to the decline in mortality rates. Finally, two state programs designed to aid in further reducing Wisconsin's losses to cardiovascular diseases are described.

Cost to society. The economic and personal loss attributed to cardiovascular morbidity and mortality is substantial. In 1977 cardiovascular disease was reported as the underlying cause in 54 percent of all Wisconsin deaths (21,183/39,325). Of this total 65 percent were due to ischemic heart disease and 19 percent were related to cerebrovascular disease, the first and third leading causes of death, respectively, in Wisconsin (Fig 1). Assuming a 70-year life expectancy, an estimated 60,000 potential years of life are lost annually in Wisconsin to cardiovascular disease deaths. In addition to premature deaths, the morbidity and premature loss of active and healthy members of families and the work force creates hardship and economic burdens on households and communities. Currently in Wisconsin an estimated 400,000 persons cope with chronic circulatory conditions.[1] Nationwide, the direct and indirect economic cost of cardiovascular diseases is estimated to be over $50 billion annually (1975).[2] Wisconsin's share is greater than $1 billion of which heart disease losses are estimated at $900 million and stroke costs total $150 million. At the same time, money spent on preventive health care is only a fraction of this amount.

Declining mortality. Mortality from cardiovascular disease in the United States has declined by more than 30 percent in the last 30 years with the majority (60 percent) of this decrease occurring during the past decade. In 1975 actual deaths fell below the one million mark for the first time in ten years.[3] Age-adjusted death rates from ischemic heart disease peaked in 1963 and by 1977 the rates had declined by 25 percent.[3] The drop in mortality for diseases associated with hypertension is even more dramatic—falling more than 80 percent for hypertensive heart disease and 35 percent for cerebrovascular disease since 1950.[3]

Declines in cardiovascular mortality rates for Wisconsin have closely paralleled national trends. For Wisconsin males this has resulted in a 30 percent decrease in age-adjusted mortality rates, from 711 per 100,000 in 1950 to 498 per 100,000 in 1977. As in the national rates, most of this decline occurred in the last ten years. For Wisconsin females

Figure 1— **Leading Causes of Death Wisconsin, 1977**



Total deaths: 39,325

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the decline in mortality rates again parallels the national pattern, beginning earlier and decreasing more than rates for males. The cardiovascular age-adjusted mortality rate for Wisconsin females fell from 523 per 100,000 in 1950 to 288 per 100,000 in 1977, a drop of 45 percent. During this same period, the corresponding reduction in noncardiovascular disease mortality was only 14 percent for males and 29 percent for females.

Wisconsin age-adjusted rates for all cardiovascular subcategories are generally lower than the United States as a whole (Table 1 and Fig 2). This is true for both sexes and for nearly every age group. In 1975 Wisconsin ranked 24th among all states and the District of Columbia with respect to age-adjusted mortality from major cardiovascular diseases. Nationwide, rates are generally lowest in the West and higher in the South and states bordering the Ohio River. Geographic variation also exists within the state of Wisconsin. Figure 3 shows average annual age-adjusted mortality rates for major cardiovascular diseases by county for the 1968-72 period. Rates ranged from 413 per 100,000 in Polk County to 623 per 100,000 in Iowa County. However, caution should be exercised in interpreting Figure 3 as the rates may be subject to chance variation, especially in counties with small populations.

Discussion. Factors responsible for recent reductions in cardiovascular disease mortality include increased public awareness and life-style modifications as well as surgical and medical advances. These have resulted in improved detection, diagnosis, and treatment of rheumatic, congenital, coronary, and hypertensive heart diseases.

Rheumatic heart disease. The incidence of rheumatic fever dropped sharply in the 1950s following the introduction of penicillin treatment for streptococcal pharyngitis. However, successful surgical intervention for those persons who already had rheumatic valvular disease was feasible only after the introduction of reliable artificial valves, hypothermia, the heart-lung machine, and other life-support techniques in the 1960s. As a result of these advances, the mortality rate from rheumatic heart disease in Wisconsin has decreased by 62 percent since 1950, a success shared nationwide.

Table 1

AGE-ADJUSTED MORTALITY RATES*
FOR MAJOR CARDIOVASCULAR DISEASES** BY SEX

Wisconsin, 1950-1977
United States, 1950-1977

	Wisconsin		United States	
	Male	Female	Male	Female
Major Cardiovascular Diseases				
1950	711	523	718	516
1960	682	458	702	466
1970	632	374	640	388
1977	498	288	529	309
% decline 1950-1977	30	45	26	40
Heart Disease				
1950	521	344	531	348
1960	494	298	520	312
1970	479	255	486	265
1977	386	204	414	219
% decline 1950-1977	26	41	22	37
Cerebrovascular Disease				
1950	135	137	136	126
1960	136	118	131	116
1970	111	89	113	95
1977	79	65	83	70
% decline 1950-1977	41	53	39	44
Ischemic Heart Disease				
1968	438	244	469	255
1977	336	177	371	191
% decline 1968-1977	23	27	21	25

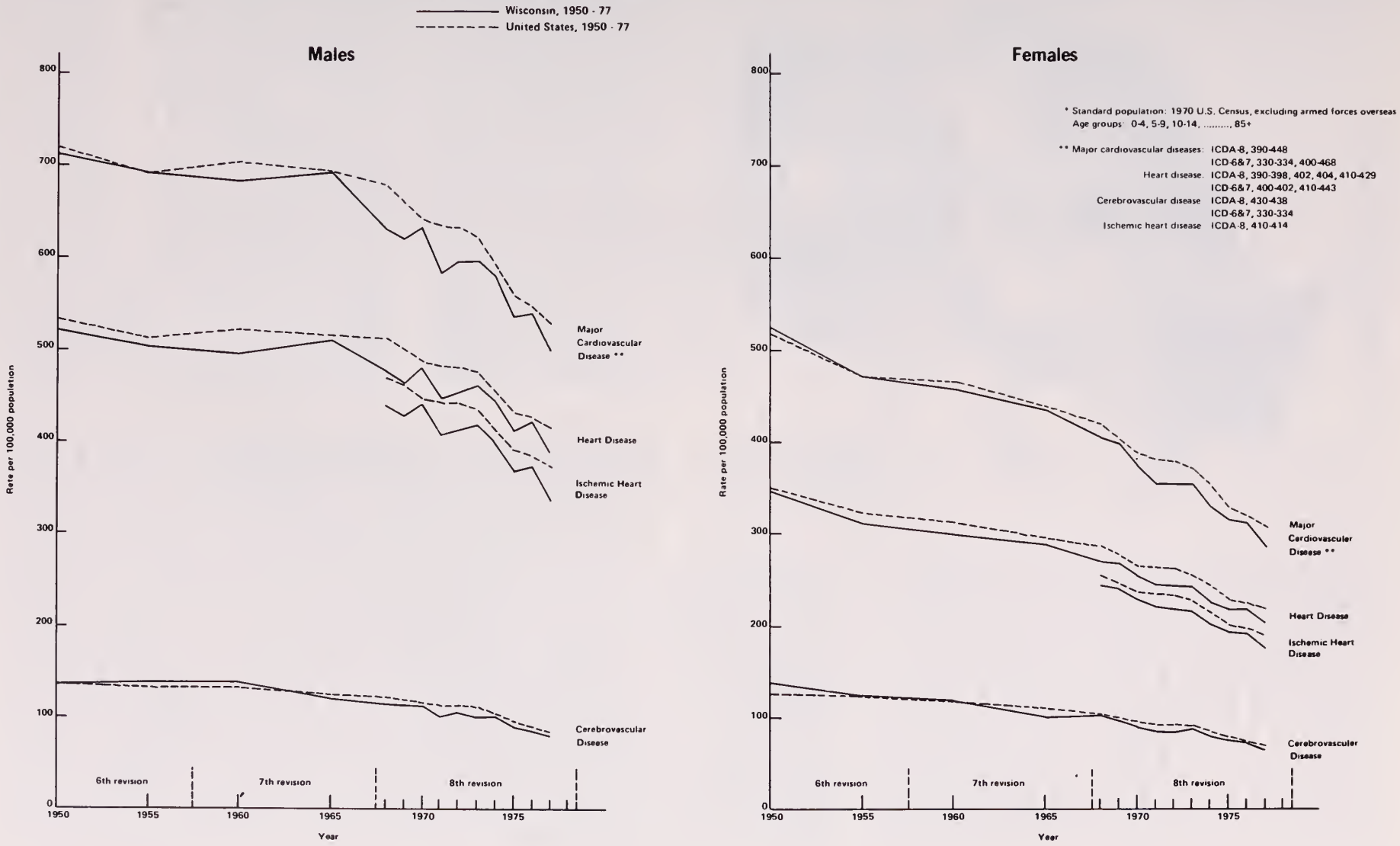
* Standard population: 1970 U. S. Census, excluding armed forces overseas
Age groups: 0-4, 5-9, 10-14, ... , 85+

** Major cardiovascular diseases: ICDA-8, 390-448
ICD-6&7, 330-334, 400-468
Heart disease: ICDA-8, 390-398, 402, 404, 410-429
ICD-6&7, 400-402, 410-443
Cerebrovascular disease: ICDA-8, 430-438
ICD-6&7, 330-334
Ischemic heart disease: ICDA-8, 410-414

Congenital heart disease. Similiar advances in acute medical and surgical care of congenital heart disease now offer a majority of affected children "complete correction" or symptomatic relief. The introduction of safer and more sensitive diagnostic procedures allows earlier detection permitting prompt surgical intervention. As a result of these measures, the mortality rate in Wisconsin from congenital heart disease has declined by 44 percent since 1950.

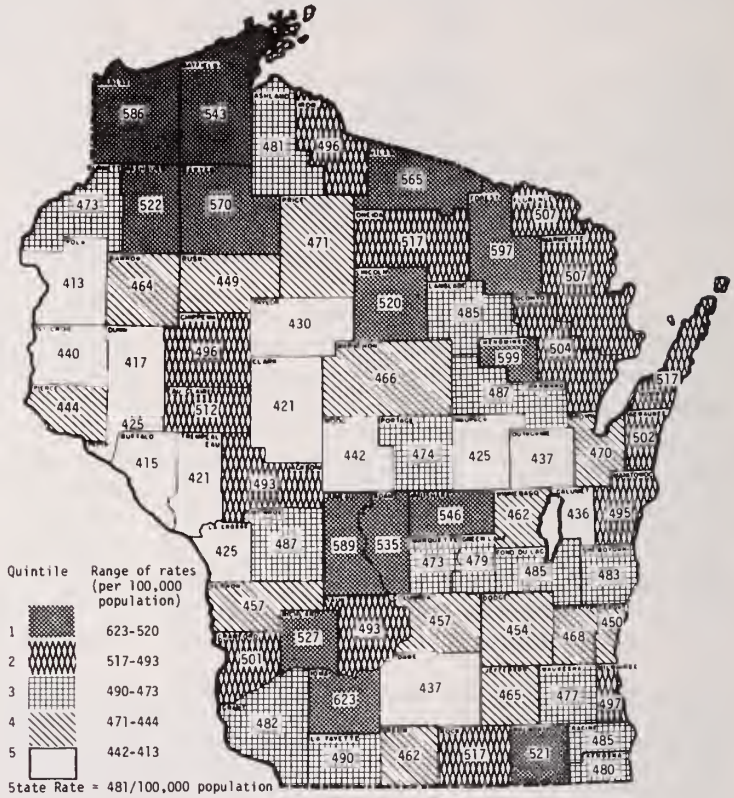
Ischemic heart disease. Coronary artery disease accounts for two-thirds of all cardiovascular mortality or over 600,000 deaths per year in the United States. Now, as in 1950, it is the single leading cause of death in Wisconsin and the United States. Yet, significant progress has been made through advances in both acute medical care and personal health behavior areas. Hospital coronary care units evolved early in the 1960s providing improved patient monitoring, emergency drugs, and resuscitative equipment. Fifty-eight percent of the general hospitals in Wisconsin now offer cardiac intensive care facilities.[4] Concurrent improvements in electrical monitoring, anti-arrhythmic drugs, and artificial

Figure 2— **Age-adjusted* Mortality Rates by Sex For Major Cardiovascular Diseases**



pacemakers have led to better control of arrhythmias, especially acutely after a major cardiac event. More recently surgeons have been able to relieve chest pain and possibly improve ventricular function by surgically bypassing diseased coronary arteries. In 1977, 1,625 cardiac pacemaker insertions, 3,515 coronary revascularizations, and 648 cardiac valve procedures were performed in Wisconsin.[5] Despite these accomplishments, sudden death is the first sign of coronary artery disease in over one-fifth of all patients.[3] This illustrates the continuing need for safer, inexpensive, and non-invasive techniques to detect, diagnose, and intervene in coronary heart diseases before a fatal first symptom occurs.

Figure 3— AVERAGE ANNUAL AGE-ADJUSTED* MORTALITY RATES FOR MAJOR CARDIOVASCULAR DISEASES** Wisconsin, 1968-72



* Standard population. 1970 U.S. Census excluding armed forces overseas
Age groups: 0-4, 5-9, ..., 85+
** ICDA-8, 390-448

Hypertension. Improvements in identification, diagnosis, and therapeutic management of high blood pressure account for much of the decline in cardiovascular mortality, as evidenced by the significant drop in hypertension associated diseases. Although stroke still ranks as the third leading cause of death in Wisconsin, its mortality rate has been on a downward trend for more than 30 years with the largest declines occurring since 1972. During the 1950s, stroke decreased less than one percent per year; in the 1960s, the decline was two percent per year, and since 1972 has been 4.5 percent per year.

The introduction of thiazide diuretics in the 1950s and more potent antihypertensive agents in the 1960s made successful treatment of high blood pressure possible. Clinical trials conducted throughout the 1960s and 1970s have demonstrated that moderately and severely elevated blood pressure could be effectively lowered with drugs and diet therapy and that adequate treatment could effectively prevent the occurrence of stroke, renal failure, and heart failure. In 1972 the National High Blood Pressure Education Program (NHBPEP) was established by the National Heart, Lung and Blood Institute in an effort to provide health professionals and the public with newly acquired knowledge on hypertension. In a combined effort with other governmental agencies and the private sector, the NHBPEP has been able to establish effective hypertension screening and follow-up programs in all 50 states. Their efforts have been successful. In 1971, national surveys revealed significant problems in awareness among the estimated 23 million Americans with high blood pressure. One-half of those with elevated blood pressure did not know they had it; over one-half of those who knew they had it were not adequately controlled; and only 17 percent of persons with hypertension were on effective treatment.[3] By 1974 awareness had increased to 71 percent and the number of persons adequately controlled was at 29 percent.[3] In addition, patient visits to physicians for hypertension were up by 50 percent since 1971, while patient visits for all causes increased by 5 percent in the same period.[3]

Risk factors and life-style. Population studies at Framingham and Tecumseh have enabled epidemiologists to identify risk behaviors associated with heart disease and stroke. Recognized major cardiovascular risk factors include age, sex, hypertension, cigarette smoking, and plasma LDL and HDL cholesterol levels. Other significant risk factors include obesity, sedentary life-style, elevated blood glucose, family history of heart disease, personality type, and stress. Using these criteria, persons at risk can be identified early, made aware of their situation, and encouraged to modify unhealthy behavior patterns.

Many positive life-style changes in health behavior areas have occurred during the past decade. Since the Surgeon General's warning in January 1964, there has been a marked reduction in the prevalence of smoking, especially among men. In 1978, 38

percent of adult males were current smokers compared to 51 percent in 1965.[6,7] Some researchers believe this could account for up to 40 percent of the observed decline in ischemic heart disease mortality among middle-aged males.[8] Unfortunately, similar smoking decreases have not occurred among women. In 1978, 30 percent of adult females were current smokers compared to 33 percent in 1965.[6,7]

In 1964 the American Heart Association recommended that persons limit their dietary intake of saturated fat and cholesterol. During the last decade, consumption of animal fats and oils, cream, butter, and eggs has decreased significantly and the average plasma cholesterol level has dropped four to eight percent.[3] Simultaneously, increasing health awareness has spurred interest in "wellness" programs and individual physical fitness, as evidenced by the recent enthusiasm for jogging and regular exercise.

Wisconsin Division of Health initiatives. The Wisconsin Division of Health, Bureau of Prevention, has introduced two programs during the past two years aimed at further reductions in cardiovascular mortality. Since January 1978 the Wisconsin High Blood Pressure Control Program has been coordinating existing local health resources for blood pressure control. The program promotes the use of nationally recommended uniform criteria on detection, referral, diagnosis, treatment, and long-term management.[9] An educational component directed at the patients and their families, physicians, and the general public is incorporated into every program. It is estimated that 528,000 persons in Wisconsin are hypertensive (17 percent of the adult population) and that 176,000 (33 percent) of them are unaware of it. To date 31 cities and counties are actively participating in the state program and have screened over 250,000 persons. In the Milwaukee area the Milwaukee Blood Pressure Program has screened more than one-quarter of a million persons. Active since 1972, the Milwaukee Blood Pressure Program has received national recognition for its leadership in hypertension control.

Early in 1980 the Wisconsin Division of Health initiated a federally funded Health Education-Risk Reduction Program designed to assist state and local health agencies in initiating, evaluating, and strengthening community health promotion and education programs. The program is intended to encourage community organization of public, private, and voluntary agency efforts to reduce the risk of premature death and disability associated with smoking and alcohol-related problems, obesity, hypertension, stress, and other preventable health conditions. This year community grants will be awarded to agencies implementing interventions to prevent adolescent smoking and alcohol abuse. It is hoped that through widespread implementation of screening and health promotion programs as organized community efforts, there will be a substantial reduction in the risks of premature death and disability from chronic diseases and ultimately reduce the overall costs to society incurred by the premature loss of productive citizens.

Conclusion. In the past advances in medical and surgical knowledge have contributed significantly to decreases in cardiovascular disease mortality. However, in the future primary prevention strategies are likely to be most rewarding. Atherosclerosis, and resultant coronary artery disease and stroke are predominantly diseases of life-style. During the past two decades the American public has demonstrated the capacity to modify and improve its health behavior. Falling cardiovascular mortality rates suggest that these changes do make a difference. For declines to continue in Wisconsin and the nation, it is necessary that individuals, with the advice and support of their physicians, assume increasing responsibility in their own health maintenance through dietary modification, smoking cessation, and regular exercise.

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Heterotopic ossification in an abdominal scar

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ALTHOUGH SOFT tissue calcification is a common phenomenon, ectopic ossification is much less common. This is particularly true when it occurs in an abdominal operation scar.

Examples of soft tissue calcification include arterial calcification, the deposition of calcium salts following necrosis of any soft tissue, and in systemic conditions associated with hypercalcemia or hyperphosphatemia.

Soft tissue ossification, or the formation of ectopic bone, even though uncommon, has been divided into three subtypes. The first is myositis ossificans progressiva, a rare disorder in which ossification occurs in the fibrous tissues of the muscle planes resulting in sheets of bone and severe disability. This condition begins in early childhood and may be triggered by a minor trauma. The second classification is neurogenic myositis which occurs in patients with spinal cord lesions. The ossification may be in muscles, tendons and ligaments, particularly around large joints. The third classification is traumatic myositis ossificans usually occurring after extensive soft tissue injury. Initially there is a soft tissue mass followed by irregular central calcification and eventually with bone maturation resulting in mature lamellar bone and even occasionally with elements of marrow. This type of ectopic bone may regress spontaneously.

Ectopic ossification in abdominal surgical scars is a rare subtype of traumatic myositis ossificans. A case in which this occurred is presented.

Case report. The patient was a 50-year-old female who had had a cholecystectomy 30 years before. The incision had been made in the right upper quadrant with splitting of the right rectus muscle fibers. Her convalescence was uneventful and she subsequently had two normal pregnancies and deliveries. Also seven years ago she had a hysterectomy because of uterine fibroids and endometriosis. Several days prior to her present admission she had been leaning over a bathtub causing pressure on her right upper abdomen. She felt a "tearing sensation" in that area and had continuous pain from that time on. On two occasions she thought she had noted a bulge in her old cholecystectomy incision. However, on examination no definite hernia could be palpated, but there was a very tender spot localized in the lower end of the old incision. She was not able to sit erect because of the discomfort. She was quite obese and was under treatment for hypertension. Her chemistry panel was reported as within normal range for all 20 tests.

It was felt that she probably had a small incisional hernia and was scheduled for surgery because of the persistent pain and tenderness. However, at operation a segment of ossified tissue was encountered in the rectus fascia and muscle at the lower end of the old scar. This apparently had been fractured from her minor trauma resulting in sharp spicules of bone stabbing into the surrounding soft tissue. The pathologist described the specimen as a longitudinal segment of muscle measuring 3 x 1 cm, and in the central portion a long shaft of osseous tissue was identified. The spicule of bone measured 2 x 0.3 cm. Microscopically the sections included an elongated segment of skeletal muscle showing a considerable interstitial hyalinization and fibrosis. In one focus there was a long spicule of histologically unremarkable bone. The pathological diagnosis was heterotopic bone formation. The defect was repaired and the patient recovered rapidly and had no further pain.

Discussion. There have been 44 cases of heterotopic ossification in abdominal wounds reported in the literature[1,2] through 1978. However, there must be many more cases of this rare condition since Pearson and Clark[1] of San Francisco added four cases that they found between 1973 and 1976, and Eidelman and Waron[2] reported five cases from Israel during the four-year period 1967 through 1971. One additional case was reported in 1980 from Yale University School of Medicine.[3] However, of all those previously reported, only three were in females, making this case even more unusual.

All of the patients with the exception of our own had vertical midline abdominal incisions, most in the epigastrium. No cases have been reported in transverse incisions. No patients showed keloid formation or hypertrophic cutaneous scars. Heterotopic bone formation after orthopedic operations on the extremities has not been reported despite massive local seeding of bony and cartilaginous particles. In none of the reported cases was there evidence of metabolic or endocrine disturbance. Bone formation did not appear to be related to suture material as surgeons used catgut, silk, cotton, and stainless steel. Nor was there any connection between the type of operation.

Almost all the patients were noted to be obese but none had any wound complications before the ossification appeared. Most cases occurred within a few months after surgery and one after only 27 days. In the case reported here there was an interval of 30 years. The ossification might have been present

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much earlier but did not become apparent before the minor trauma.

Summary. Heterotopic ossification of abdominal wounds is a rare complication after surgery, but it can cause severe abdominal discomfort. Diagnosis can be established by lateral roentgenograms of the abdomen or bone scan and ultrasonography. Treatment consists of surgical removal, and recurrence after excision is reported to be extremely rare. Only 45 cases have presently been recorded.

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Disulfiram neuropathy

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ABSTRACT. *A 30-year-old man developed signs and symptoms of a distal sensorimotor polyneuropathy after taking disulfiram, 500 mg daily for 12 months. He showed both clinical and electrophysiologic improvement following withdrawal of his medication. General practitioners, internists, psychiatrists and others treating alcoholic patients should be aware of this potential complication of disulfiram therapy. Because neuropathy in alcoholics is frequently attributed to the effects of alcohol and coincident nutritional deficiency, disulfiram neuropathy is likely an under-diagnosed entity.*

PERIPHERAL NEUROPATHY occurring in the context of chronic alcoholism with associated nutritional and vitamin deficiency is well recognized. Although previously described in the literature,[1,2,3,4,5] the association between disulfiram (Antabuse®) therapy and peripheral neuropathy is not widely appreciated. It is the purpose of this communication to present a case of distal sensorimotor neuropathy that developed during the course of disulfiram therapy. Both clinical and electrophysiologic improvement was seen to occur following discontinuation of the drug.

Case report. The patient was a 30-year-old man with a ten-year history of episodic binge drinking, often remaining intoxicated on weekends and his days off. Eighteen months prior to his initial evaluation he was started on disulfiram, 500 mg daily, and according to both the patient and his family he was able to achieve complete sobriety. Six months prior to admission he began to experience cramping in his calves, tingling and numbness in his feet, and some difficulty walking on his toes, particularly in the dark. Over the next several months his gait became progressively more disturbed and he had to shift his weight to the balls of his feet when standing. Three months prior to admission he began to note an impairment in handwriting which he attributed to incoordination and loss of feeling in his fingertips. He denied any visual complaints. There was no family history of neurologic disease or exposure to occupational toxins or heavy metals. The patient was not a diabetic and was taking no medication other than disulfiram. The patient's weight had been stable, he was eating regularly, and despite his progressive impairments was able to remain gainfully employed in a semi-professional capacity.

The examination revealed a well-nourished man who was alert, oriented, and cooperative. The general medical examination was unremarkable. The cranial nerve examination including optic funduscopy was completely normal. The gait was abnormal showing a mild but definite steppage quality presumably related to early bilateral foot drop. Detailed motor testing showed obvious distal weakness confined predominantly to the intrinsic muscles of hand (4/5 BMRC) and feet (2/5 BMRC). There was obvious wasting of the intrinsic muscles of the feet and no voluntary movement of toe flexors was possible. Deep tendon reflexes were absent at both ankles, otherwise normal. The sensory examination disclosed hypesthesia to light touch, pin prick, and vibration in a stocking and glove distribution with sensory shading at the mid-calf and mid-forearm regions respectively. Proprioception was impaired in both feet. Peripheral nerves were not palpably enlarged and Tinel's sign was absent on percussion of ulnar, median, and peroneal nerves. There were no long tract signs and the Babinski responses were absent bilaterally.

Laboratory blood studies revealed normal values for complete blood cell count, sodium, potassium, chloride, bicarbonate, blood urea nitrogen, blood sugar (nonfasting), serum glutamic oxaloacetic transaminase, lactic dehydrogenase, serum glutamic pyruvic transaminase, alkaline phosphatase, total calcium, albumin, and total protein. The Westergren sedimentation rate was 4 mm/h. The serum B_{12} level was 381 pg/ml, and the folate level was 6.0 ng/ml. The blood lead level was 20 μg/dl (normal less than 40).

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Motor nerve conduction velocity for the right common peroneal nerve could not be recorded due to wasting of the extensor digitorum brevis muscle. The segmental forearm conduction velocity of the right median nerve was reduced for both motor and sensory parameters: 46.2 and 47.2 m/sec respectively. Distal motor latency of the median nerve measured from the wrist to the onset of the compound muscle action potential recorded from the abductor pollicis brevis muscle was prolonged (4.8 ms). The right median nerve sensory latency measured from the wrist to the peak of the digital sensory action potential recorded from the index finger was prolonged (4.2 ms). The resting needle electromyographic exam recorded from the right abductor digiti minimi quinti showed signs of active denervation manifested by continuous positive sharp waves and fibrillation potentials.

Disulfiram therapy was discontinued and within one month the patient noted subjective improvement, particularly in his upper extremities. A detailed reassessment was performed four months later. At that time the patient's gait had returned to normal. Bilateral wasting of the intrinsic muscles of the feet was still evident although the patient was now able to voluntarily use his toe flexors. Dorsiflexion of the feet was virtually normal. Vibratory sensation below the ankles was still impaired although other sensory modalities had normalized in the lower extremities. Both motor and sensory function had returned to normal in the upper extremities. The ankle jerk reflexes remained absent as before. Although the median nerve distal motor and sensory latency values remained marginally prolonged, the forearm segmental conduction velocity had normalized in both cases (54.2 m/sec). The conduction velocity in the common peroneal nerve was again unobtainable due to residual intrinsic foot muscle wasting.

Discussion. The present case demonstrates the classic signs and symptoms of a distal symmetrical sensorimotor polyneuropathy. The clinical course is not unlike those cases previously described in association with disulfiram, and to date there have been fewer than 30 reported cases including the present one.[1,2,3,4,5] The finding of mild-to-moderate slowing of nerve conduction velocity associated with rather marked denervation of distal muscles suggests a disease process of axonal degeneration rather than segmental demyelination. Although histopathological correlation is lacking from the present case, Moddel et al[4] have demonstrated degeneration of both axonal and myelin components of a sural nerve biopsy specimen. Axonal degeneration appears to occur first and myelin breakdown then follows. The entire process appears reversible once the disulfiram is discontinued.

Disulfiram exerts a biochemical effect by inhibiting the enzyme aldehyde dehydrogenase thus allowing for the accumulation of excessive quantities of acetaldehyde in the presence of ethanol. Disulfiram has been reported to produce optic atrophy[12] and encephalopathy[6] as well as neuropathy. How the drug exerts either a central or peripheral neurotoxic effect is not known. Suffice it to say, it appears clear that a drug-alcohol interaction is not required for toxic effects to occur. Thus, a direct, possibly dose-dependent, toxic effect of the drug or a metabolite (carbon disulfide) is suggested. The most tenable theory at present centers on the possible role of carbon disulfide—a substance known to be capable of producing axonal neuropathy in animals[7,8] and in man.[9,10,11]

Summary. It is surprising that so few cases of disulfiram neuropathy have been reported considering the widespread use of this medication. One can certainly speculate that many more cases exist but have been attributed to other factors including the toxic effect of alcohol, nutritional deficiency, and avitaminosis. Since the neuropathy may be reversible following discontinuation of the drug, it behooves the clinician to consider this diagnosis in any of his alcoholic patients receiving disulfiram who develop signs and symptoms of neuropathy.

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Perinatology
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Pregnancy testing—principles and practice

Ray V Haning, MD, Madison, Wisconsin

EDITORIAL COMMENT. *Over the past several years pregnancy testing has evolved from the cumbersome, not too specific biological tests to the sophisticated radioimmunoassays presently available. The practical clinical implications of the changes introduced in the newer pregnancy tests make it mandatory for the clinician to be fully aware of what the current concepts are. The following article provides a detailed review of the types of tests and their use in specific clinical situations.*—LBC

General principles. All laboratory systems of pregnancy testing have been based on the detection of human chorionic gonadotropin (hCG) in either blood or urine. This includes the early animal testing procedures which are no longer in use. HCG is a sialoglycoprotein with a molecular weight of 56,000 for the protein core. The carbohydrate content is 40% and the sialic acid content is 9%. HCG is made up of two subunits held together by noncovalent forces, the alpha and the beta subunits. The subunits can be separated in proprionic acid or 10 molar urea. The alpha subunit of hCG is shared with LH, FSH, and TSH. This is important from the view of pregnancy testing since antibodies to the whole hCG may crossreact with LH, FSH, and TSH based on the shared alpha subunit. HCG begins to be detectable in human blood and urine shortly after implantation occurs when extremely sensitive methods are used. The half life of hCG (time for disappearance of 50% of hCG in blood) is approximately 24-36 hours. HCG is quite stable in frozen samples, and samples can be stored for years.

Modern *in vitro* pregnancy testing systems have all been based on detection of hCG using antibodies specific for hCG. By the time of the missed period the hCG concentration is nearly always over 25 mIU/ml and often over 200 mIU/ml. In abnormal pregnancies (threatened abortion or ectopic) the hCG concentration may be much lower, but usually over 25 mIU/ml. By four weeks after conception (two weeks after the missed period), the concentration of hCG is nearly always over 1500 mIU/ml. Currently available tests can be divided into four categories: hemagglutination inhibition reactions, latex agglutination inhibition reactions, bovine corpus luteum radioreceptor assays, and radioimmunoassays.

Urinary testing procedures. The simplicity of the urinary tube testing procedures has lead to their introduction as self-administered pregnancy tests available across the counter in drug stores. Many of these tests are actually more sensitive than the older first generation pregnancy tests. However, exaggerated claims of sensitivity, lack of experience, and lack of confidence in the outcome have made this mode of pregnancy diagnosis less than ideal. A well equipped laboratory should be able to exceed the sensitivity and accuracy of these kits at a competitive price.

The first generation of immunologic pregnancy tests is based on antibodies to intact hCG. These include both hemagglutination inhibition tests and latex agglutination inhibition tests. In these systems the hCG is linked to the tanned sheep red blood cell (for the hemagglutination inhibition reaction) or to latex particles (for the latex agglutination inhibition reaction) and an antibody to hCG is either reacted first with the urine or directly with the urine-particle suspension. In the absence of hCG in the urine specimen, an agglutination of the latex particles or red cells is produced by the antibody. This is detected by the flocculation of the latex particles or formation of a mat as the red cells settle to the bottom of the test tube. When hCG is present in the urine specimen, the hCG combines with the antibody (saturating the active sites and inhibiting the agglutination reaction). This inhibits the formation of the agglutinated latex particles producing a smooth latex suspension or inhibits the red blood cell agglutination producing a small donut in the center of a test tube as the red cell suspension settles and the unagglutinated red cells are able to roll down the side of the round tube bottom as they settle. The presence of protein can interfere with these reactions but newer tests appear to be less sensitive to the protein effect due to a switch to covalent bonding of the hCG to the particles.

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The concentration of hCG in blood and urine is quite similar. Urine offers a relatively protein free biological fluid relatively well adapted to use in hemagglutination inhibition reactions and latex agglutination inhibition reactions due to the low protein concentrations. In the presence of high urinary protein concentrations, it is wise to view these testing procedures with caution unless the concentration of urinary protein is below the levels known to interfere with the test. The drawback to urinary testing procedures is that the salt concentration of urine varies widely depending on the physiological status of the patient.

Changes in salt concentration are able to modify antigen-antibody reactions by nonspecific effects. The concentration of electrolytes and serum proteins are carefully controlled in peripheral blood. Thus, serum has the advantage of very stable concentrations of electrolytes and a relatively stable protein concentration minimizing nonspecific salt effects.

As the first generation of urinary tests used an antibody to intact hCG, they had to be made relatively insensitive (by using relative large quantities of the antibody) to insure that LH did not produce false positive reactions. This limited the practical sensitivity to about 500 mIU/ml hCG. With the introduction of antibodies formed by immunizing the animals (usually a goat or a rabbit) with beta subunits of hCG, the specificity of the antibodies improved markedly and it became possible to measure concentrations of hCG as low as 5 mIU/ml by radioimmunoassay in the presence of very high concentrations of LH (as is encountered in specimens from postmenopausal women). This led to the introduction of the second generation of latex inhibition tests and hemagglutination inhibition tests for urine with sensitivities down to about 250 mIU/ml.

Serum testing procedures. The use of serum takes advantage of the stability of serum electrolytes and protein to produce very accurate tests. Current serum tests use ^{125}I radioactive hCG. The displacement of tracer hCG is detected by a drop in the bound counts. A standard is used for comparison. The bovine corpus luteum receptor is able to bind human hCG or human LH. It is not as discriminating as the antibetasubunit hCG antibody, and hence it is sensitive to false positives due to reaction with high levels of LH in the specimen. Although the nature of the receptor would permit greater sensitivity, the concern about false positive reactions has limited the practical sensitivity of the test to 200 mIU/ml. The high specificity and sensitivity of the antibetasubunit antibody has made systems based on this antibody more sensitive than either the radioreceptor assay or assays based on whole molecule antibodies. The introduction of rapid systems for incubation and separation of free from bound antibody has allowed development of rapid (less than two hours) turn around times for serum pregnancy testing with sensitivities as low as 10 to 25 mIU/ml.

The limit of current technology for radioreceptor assay is 200 mIU/ml with a speed similar to that of the betasubunit radioimmunoassay. The urinary pregnancy testing systems with the betasubunit antibody achieve a sensitivity of approximately 250 mIU/ml in a 90-minute incubation time. The one to two minute slide tests (latex agglutination inhibition) achieve a sensitivity of approximately 1000-3500 mIU/ml.

Practical considerations in pregnancy testing. Understanding how to choose between tests is important both for the physician and for the laboratory. Although the radioimmunoassay and the radioreceptor assay are more sensitive than urinary pregnancy testing methods, they both require the use of ^{125}I labeled tracer hCG and gamma counters. The gamma counter is expensive and may not be available in all laboratories. The two-minute slide pregnancy tests are more rapid than either the urinary tube tests or the tests relying on radioactive tracers. They require very little equipment and can be performed in small facilities such as school health services or family planning clinics. However, they are 100 times less sensitive than the serum pregnancy tests based on betasubunit antibodies and 10 times less sensitive than the new generation of urinary tube tests for pregnancy. In addition, the end point is less clear and both false positive and false negative reactions are higher than in any other type of test. Only the tests based on radioimmunoassay with betasubunit antibodies are sensitive enough to pick up the abnormally low concentrations of hCG seen in early ectopic pregnancies. Thus, urinary pregnancy testing procedures and radioreceptor assays with a sensitivity of more than 25 mIU/ml may lead to confusion in the diagnosis of suspected ectopic pregnancy.

Accuracy in pregnancy testing is very important. A false negative test can mean the need for repeat testing at a later time, a missed diagnosis, or a disaster (*eg,* a missed unruptured ectopic pregnancy which ruptures in a remote area after leaving the office or hospital). The mortality rate in ruptured ectopic pregnancy may be as high as 10%. On the other hand, a false positive test may precipitate unnecessary surgery (termination of pregnancy or laparoscopy) and unnecessary panic. Each test kit should be evaluated with respect to occurrence of both false positives and false negatives in the laboratory where it is to be used. It is also important to evaluate the sensitivity of a test kit in the light of the question being asked.

Clinical questions. *Rule out unruptured ectopic pregnancy:* Here, the most sensitive pregnancy test with a small false positive rate should be used. If

available, this would be a serum pregnancy test based on a betasubunit antibody with a sensitivity of about 25 mIU/ml. Lower sensitivities with a short turn around time may have too high a rate of false positives to be acceptable. Slower turn around times may be unacceptable because of the need for a rapid answer for patient management. Tests less sensitive may be of some help but only if positive since there may be false negative tests if the test sensitivity is above 25 mIU/ml. If a less sensitive test is negative, the test does not rule out the possibility of an ectopic pregnancy.

Rule out ruptured ectopic pregnancy: Here speed and clinical judgment are of the utmost importance. A culdocentesis (passage of a needle transvaginally to attempt aspiration of blood from the cul-de-sac) should be done immediately. Culdocentesis can be performed rapidly in an outpatient setting without the need for general anesthesia. If positive, the patient should be taken to surgery. Depending on the clinical findings, either laparoscopy or immediate laparotomy may be appropriate. If the culdocentesis yields no blood, then a serum pregnancy test is useful.

Early pregnancy diagnosis (before two weeks after the missed period): Here accuracy and sensitivity are very important. The most sensitive test available should be used. The serum pregnancy test based on a betasubunit antibody is ideal (sensitivity of 25 mIU/ml). If this is not available, the radioreceptor assay (sensitivity 200 mIU/ml) or the second generation urinary tube test (sensitivity 250 mIU/ml) is the second choice. The two-minute slide tests are expected to be negative due to lack of sensitivity.

Routine pregnancy testing (two weeks after the missed period): Here any of the tests may be positive. However, the importance of accuracy (lack of false positives and false negatives) is still very great. The best tests here are the serum radioreceptor or serum betasubunit tests. However, the urinary tube tests are nearly as good as long as there is no proteinuria. The urine slide tests are less desirable unless time is an important factor because of the higher occurrence rate of false positives and false negatives.

Stat pregnancy testing: This may be done most rapidly using the two-minute urinary slide tests. However, the pregnancy must be relatively advanced (two weeks or more past the missed period) or the test will be falsely negative. If the test is "stat" because of a concern for a possible ectopic, the urinary slide test will not help, and a 25 mIU/ml serum pregnancy test is the best choice. If a serum pregnancy test is not available, then a second generation urinary tube test (250 mIU/ml, turn around time = 90 minutes) is more desirable than the slide test (remember that if there is a question of a *ruptured* ectopic, the physician should do an immediate culdocentesis rather than waiting for *any* pregnancy test).

Monitoring hCG in treatment of trophoblastic disease: Here a previously fatal tumor has been brought under control by a combined surgical and chemotherapeutic approach. The ability to follow hCG concentrations accurately has played a key role in directing the chemotherapy, and it has allowed the early detection of recurrence long before any symptoms occur. This method demands the utmost in sensitivity and specificity. The sensitivity of the method should be 5 mIU/ml in the presence of high concentrations of LH. We routinely run a postmenopausal serum control with each assay and report this value along with that of the patient. Values less than that of the postmenopausal serum control are not distinguishable from zero. This test is a quantitative radioimmunoassay for hCG using a betasubunit antibody. For this purpose, sensitivity and accuracy are much more important than speed. Serial dilutions are run if necessary as the range may be from 6 mIU to 6,000,000 mIU or more.

There is no one best test. The choice of a test depends on the trade off between availability, speed, accuracy, and clinical need. A sound understanding of pregnancy testing and diagnosis both by the laboratory and by the physician is necessary to optimize patient care. ■

CORRECTION: In the March issue there is an error in the article, "Probable carbon dioxide embolism during laparoscopy; case report," by Nichols, Tompkins, and Henderson. On page 28, second column, last paragraph, third and fourth lines state erroneously that in the management of CO_2 embolism the patient should be hyperventilated with 100% carbon dioxide. Stated correctly, the patient should be hyperventilated with 100% oxygen (O_2). Under no circumstances should any patient or subject be ventilated with 100% carbon dioxide.—*Bonnie M Tompkins, MD*
Wisconsin Medical Journal

Acute pain is no laughing matter.

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CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

Interaction with other central nervous system (CNS) depressants: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the severity of the pain and the response of the patient. It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

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President Motzel . . .

Report to the House of Delegates as President-elect

Strength through individual responsibility. . . Responsibility through collective involvement

ONLY A FEW MONTHS ago the electorate of this country voted to alter the direction that the nation had been following for nearly 50 years, a direction that has constantly been decreasing individual responsibility. That responsibility was replaced by regulation and programs defined and funded by that segment of government most distant and insulated from those regulated and the recipients of the presumed benefits those programs afford.

In spite of political attempts to confuse the issues, voters did clearly understand and did sincerely desire this change. However, they understood much less well how immersed they individually had become in the system, how comfortable they had become in avoiding the effort necessary to make difficult decisions and, even more, the responsibility for the consequences of those decisions.

It has been convenient for all of us to criticize regulations and programs we construed to be poor, especially if we were given no opportunity, or if we neglected when asked, to contribute information or opinions to the development of those regulations and programs.

Within our profession many physicians felt initially relieved at the prospect of this change of direction. Suddenly the threat of national health insurance or "socialized medicine," federally mandated (*and regulated*) health planning, PSRO activity, all seemed about to fade from the scene. Once again we could "practice medicine." Gone would be the aggravating concepts given reality by such phrases as "justification of admission," "length of stay," "certificate of need," and all the other phrases with which we have become familiar over the past five or ten years.

But even in the short interval that has passed since last September—even to the least informed, even to the most conservative—it has become painfully apparent that 1981 is not 1946, or even 1964. The social programs and problems recognized and the expectations awakened over those 35 or 17 years remain. These legitimate problems would more than tax our ingenuity, but, in addition, we are faced with the gigantic programs constructed by numerous inept social planners who for years have been able to experiment on a grand scale without constraint or regard for the consequences.

We are now being called upon to dismantle these cumbersome and complicated programs, to sift the essential from the inflated, need from desire. This is made enormously more difficult by the fact that we have all become habituated, if not addicted, to government support and funding for every variety of perceived good. Remember, we, too, are victims. Many dollars of our fees come from government sources. Nor are they any longer compared to fees we might never have been paid in the past but rather they are compared with our "usual" charges. Rightly or wrongly, we have all fallen victim to this government largess.

But now many decisions will be made closer to home. We *will* be consulted now on how to distribute the "block grant" that will replace only a portion of the "categorical" funding of the past; which programs are of least value; who should receive the funds available, and in what proportions. Yes, we will be asked, partly because we have spent time and effort establishing good working relationships with those charged at the state level with these decisions; partly because we have, collectively, information that is necessary to make these decisions; and partly, perhaps mostly, because these decisions to reduce programs are unpopular and it is comforting for those responsible to share that responsibility with others.

But for whatever reason, as citizens, as expert (again collectively), in many aspects of medical care and its delivery, it is our duty to participate. More, it may be our last chance to participate, because if this attempt at changing the direction of responsibility in this country fails—especially if it fails for lack of interest or participation on the part of those who have criticized the result of centralized planning over the past 15 years—we are unlikely to be offered another opportunity.

We must prepare ourselves—our Society—to respond, even to initiate solutions by working together to prepare well analyzed, coherent proposals. Even within our own Society there will necessarily be areas of disagreement. These must be resolved, first for the greatest good of our patients and, secondarily, for the greatest good of our entire profession. If we can bring ourselves—all of us, all physicians in the State of Wisconsin—to partici-

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> **"The President's goals for 1981-82: 100 percent physician membership and participation; dialog at all levels with hospital administrators and nurses; formation of a strong coalition between medicine and industry; increased cooperation between the Society and its Auxiliary—all pertain to strengthening the Society, first internally by strengthening its financial base and improving the breadth of representation, and then with the confidence achieved through strength and a broadly disseminated knowledge of the issues, to work with others vitally concerned with the future of delivery of medical care."**

pate in these decisions and support them with our membership in this Society, we shall succeed in providing the best possible medical care to our fellow citizens and contribute significantly by our example of leadership to the future healthcare of this nation.

To these ends I would like to propose several goals for the Society in the coming year. The first of these has been implied above. That is 100 percent of the physicians of Wisconsin as members of this Society—whether they be actively practicing physicians individually or in groups, academicians engaged in teaching or research, graduates of medical schools outside of this country, certainly our women colleagues, our residents and our medical students, physicians working for industry and for government, and last but not least, our retired and semi-retired physicians whose perspective can be so valuable to us. There is no doubt that each of us can find a reason that this or any other society does not represent him or her perfectly. That, ladies and gentlemen, is a "cop out." As a professional who accepted a position, at least partly subsidized in a school of medicine, each physician has incurred an obligation to medicine and to society that is not fully satisfied by any organization of more limited scope.

Yes, there are also financial concerns, but, as we have attempted to address them in the revision of the Constitution and Bylaws, they are generally not out of proportion to other groups in our society and are well within the limits of the value received. Many in our Society contribute not only those dues but an extra ordinary amount of their own time as well.

A second goal that I would propose—perhaps more controversial than the first, and certainly less directly under our control—is that of increased dialog with two major components, along with ourselves, in the delivery of medical care in 1981: the administrators of our hospitals and, probably our closest allies in the delivery of care, the nurses of Wisconsin.

While there are certainly areas in which we have divergent views (or perceive that we do), it seems untenable that we should not present a united front in those areas of patient care on which we can agree—and make every attempt to resolve those perceived and even those real differences, again, focusing on the greatest good of the consumers of medical care, those people we used to call "patients." I submit that in the planning of future delivery of affordable medical care, we remain divided at our own peril.

The above dialog also is critical not only at the state level but in each hospital and in each community throughout our state—all of us must become involved.

The third goal is really a continuation of an objective initiated by Dr Russell Lewis during the past year, and that is the formation of a meaningful coalition with the leaders of industry in our state and local communities. These industrialists are vitally interested (perhaps more interested than government itself) in the control of medical costs, for to a large degree they are paying these costs at the price of their own competitiveness in the national and world markets. It is of little importance initially whether the problem is failure of the physician to ration (and I use that word advisedly because I think some of our industrial friends feel that's what our position should be), to ration care of the patient or the fault of industry in bargaining away first-dollar coverage so that each employee looks on medical care as part of his/her wage to be used for *something,* or lost forever. Of importance is understanding between us and at least a real attempt to restore responsibility for cost to each of the parties involved—the employer, the government, the union, the insurer, the physician, and last, but certainly not least, the patient. Again, not an easy task and certainly one that we will never achieve alone.

The final goal that I would recommend for the coming year is again a continuation, a reemphasis of something that has been growing during the recent past, and that is a closer relationship with our own Auxiliary. Many members of the Auxiliary have been invaluable in recent years through their participation in political as well as civic and community activities. While we in no way wish to encroach on those activities which they have so well initiated and performed throughout the years, neither should we nor the Auxiliary overlook the value of coordinating

> **"Issue of importance: We will be supporting, along with the Medical Examining Board, legislation to require reporting and dissemination of information concerning significant disciplinary action taken by a hospital staff against a physician."**

some of those projects by appropriate representation at county societies, and at our committee and commission levels. To this end I will ask the President and President-Elect of the Auxiliary to meet with the Executive Committee of the Council so that both organizations are fully and currently informed with regard to political issues as well as current activities of each organization.

At this point I would like to digress briefly to call your attention to a few issues of great importance which will occupy the Society in the immediate future.

We will be supporting, along with the Medical Examining Board, legislation to require reporting and dissemination of information concerning significant disciplinary action taken by a hospital staff against a physician. This will be under the jurisdiction of the Medical Examining Board with appropriate statutory safeguards and will help to solve a problem that we have all recognized of a physician, albeit a rare physician, with a problem affecting the care of his patients moving from one community to another, leaving that problem to be rediscovered by each medical community.

We will continue surveillance of the recommendations to, and the activities of, the Board of Governors of the state-operated liability insurance plan so that physicians continue to have appropriate input into the final decisions.

Recently, review of actuarial recommendations, including the employment by the State Medical Society of an independent actuary to review those recommendations made to the Board, has resulted in savings for physicians that in the lowest insurance category would pay the dues of a physician of the State Medical Society for one year.

(This at least should have meaning to those physicians who have failed to join their colleagues as members of the Society leaving others to pay for the benefits they enjoy.)

Also much staff and physician time is being, and will be spent in discussions with the Governor, the legislators, and the Department of Health and Social Services regarding both the restructuring of the Department so as to provide appropriate attention to its public health function as recommended by a committee of this Society last year, and the very difficult task of recommending areas in which the inevitable reduction in funding of the Medicaid program can be applied with the least reduction in essential patient services.

Further advice from this Society will likely be sought on the issue of physician distribution in the state, an issue which brings with it very difficult problems of financing of medical school programs—both undergraduate and graduate—student loans and student loan forgiveness, and equity of fee schedules both geographically and specialty-wise.

“Issue of importance: Advice from this Society will likely be sought on the issue of physician distribution in the state, an issue which brings with it very difficult problems of financing of medical school programs—both undergraduate and graduate—student loans and student loan forgiveness, and equity of fee schedules, both geographically and specialty-wise.”

“Issue of importance: Discussions with the Governor, the legislators, and the Department of Health and Social Services regarding both the restructuring of the Department so as to provide appropriate attention to its public health function.”

“Issue of importance: We will continue surveillance of the recommendations to, and the activities of, the Board of Governors of the state-operated liability insurance plan (WHCLIP) so that physicians continue to have appropriate input into the final decisions.”

These are a few examples of issues current and ahead which should adequately alert you and all the physicians of Wisconsin to the need for individual support and participation.

The goals earlier outlined: 100 percent physician membership and participation; dialog at all levels with hospital administrators and nurses; formation of a strong coalition between medicine and industry; increased cooperation between the Society and its Auxiliary—all pertain to strengthening the Society, first internally, by strengthening its financial base and improving the breadth of representation, and then with the confidence achieved through strength and a broadly disseminated knowledge of the issues, to work with others vitally concerned with the future of delivery of medical care.

Hopefully from working together cooperatively with our various vantage points, but with the good of the patient always our overriding consideration, we can achieve a system that is fair and equitable in the distribution of services, compassionate, and cost-effective as we move into a future of greater individual responsibility. ■

Past President Lewis...

Report to the House of Delegates as President

Strength through accomplishment... Accomplishment through involvement

AFTER SPENDING a year as your president, it might be proper to go through the accomplishments of the year and it might be just as appropriate to list and dwell on some of the things that have not been accomplished—things on which the Society will need to spend more time. However, I have elected to talk about two things I know the least about: The first is women and the second, money.

In this day and age most of you know the term "Woman's Auxiliary" has been changed by dropping the "woman's" part. We do have some husbands who are active in the Auxiliary and we can anticipate many more as we see an increasing number of women entering the profession.

My county society has never had an auxiliary until today. It is my understanding that they are now taking our group in because a number of spouses in Wood County have decided to form an auxiliary.

The physicians in Marshfield taught me 35 years ago that the Auxiliary was made up of a group of women who alternated their time between telling their physician-husbands how to run their practice and holding style shows. Those of you who have attended previous House of Delegates meetings and those of you who have active auxiliaries have long since learned that that concept is not correct, and probably never was.

One of the more pleasant aspects of the president's job is to work on a first-name basis with the Auxiliary. I think it is important that you as leaders of our Society have my perspective of this organization.

The thrust of today's Auxiliary is not in the area of style shows. They are partners with their physician-spouses, their interests are the same, and they are willing and anxious to promote those interests to the best of their ability. They also have a unique opportunity of approaching these interests from a different viewpoint. However, most of their activities are in the area of public relations and education. I am sure that many of you in this House know that the image of medicine, particularly in the legislative arena, has improved remarkably in the past seven or eight years. While much of the credit must go to the Physicians Alliance, I am sure the Alliance would be the first to say that one of the reasons for its success is the tremendous work done at the local level in the political field by the Auxiliary. Without this effort the contacts and money supplied by the physicians would not have been sufficient to create this marked change in attitude. Undoubtedly the work of the Auxiliary in supplying time and effort to those candidates whom we have backed at election time has been one of the major factors in organized medicine's obtaining the ear that we believe we have in Madison today.

A year ago, as your president-elect, my theme song basically was that medicine was no longer an island; we have to work with other groups. One of my major disappointments in the past year has been that we have not particularly become closer to some of those allies, other health providers. Last year I left the Auxiliary off the list of that group of providers; but in retrospect I would say, having discovered that working with the Auxiliary in a true partnership arrangement, a closer alliance with that group can do more for medicine than alliance with perhaps all the others put together. We, as leaders, should promote our friends and our spouses in this effort.

Money, on the other hand, is the second subject on which I want to spend a few minutes. It covers a multitude of sins. Perhaps, as one of my friends says, it's the universal language. To me it represents the most pressing problem facing medicine today.

Our image as physicians is that of a rich group of people. Somehow we haven't impressed the public that while we make a good living, our activities should benefit the public more than, let us say, the field of entertainment or professional sports where the income is considerably greater than in the medical field.

Despite the fact that people today receive high quality care, the public now looks at the increasing cost of medical care as a nationwide problem. As such it will be controlled. The federal government has been trying to do this now for a number of years without any true impact on the cost.

We now have an administration in Washington pledged to do something about inflation and taxes.

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> **"We, as a Society, have got to concentrate on our accomplishments rather than waste time talking about our apprehensions. We have to focus on our achievements rather than our fears. We have to get involved with friends such as the Auxiliary, and we have to become involved in financial discussions."**

Government pays the highest percentage of the medical bill. It is going to look at this cost with a close eye and make a sincere effort to do something about it. To the administration this means controlling costs by controlling what we do, how we do it, and for how much.

At the present time planners are talking about the competitive role. Those of us who have been in competition all of our lives aren't quite sure what they mean, but I suspect we will find out in the next two or three years. I've been impressed by the fact that what I consider to be knowledgable people are quite convinced that if Mr Reagan's approach—the competitive type of approach—does not succeed in the next four years, we will see our profession regulated much more tightly than anything we have known in the past. We certainly hope he succeeds.

Because of the involvement of the Federal Trade Commission with physicians' fees beginning five or six years ago, most county societies, on the advice of attorneys for the State Medical Society, have chosen to stay out of reimbursement mechanisms for fear of federal action. You are all familiar with the fact that on one hand one branch of the federal government is telling us to do something about fees, and another is telling us that they will sue us if we do. For many of us it has been the most convenient excuse not to get involved in an extremely difficult, painful area—what is proper reimbursement?

As a result of our inability to solve this reimbursement problem, we continue to see government and third-party carriers being willing to do something about it. Annually the federal government has decreed what percentage of increase we may have in our fees for our Medicare patients. Until this year that amount has also been accepted by the state government for Medicaid reimbursement.

As you know the Governor is proposing that, regardless of what Washington may say on Medicare, the reimbursement for Medicaid services of physician providers be limited to 4.5 percent. You also remember seeing recently in the newspapers the fact that the Milwaukee Blue Shield plan will not pay more than the 9 percent increase on any physician's fee profile in 1981. As president of your Society, I have had more contact from members on this issue than anything else. The question always asked is: "What is the State Society going to be doing about it?" My answer has to be "nothing," because, as I see it, unless we can stand together and come in with a better proposal, that's the way it's going to be.

In essence, in the future our fees are more and more going to be set by third-party carriers and governments. Other insurance companies are doing the same thing but without as much publicity. There are some areas that lend themselves to some degree of action if we are willing to take the necessary steps.

Traditionally in recent years the percentage of increase in our fees has been across the board, so that if a cardiovascular surgeon is now getting $3000 for an operation, his 10% increase, if that's what it is, will make the fee $3300 next year. However, a family practitioner or a pediatrician taking care of a child in their office is probably getting around $15.00; and when their fee goes up that 10% next year, he will be getting $16.50. That gap is promoting a very inequitable distribution of fees, and it is becoming progressively worse. I think the relative value scales of 20 years ago are out of date and have to be changed.

The House of Delegates, as most of you remember, twice has taken action on equality in reimbursement particularly from a geographic standpoint. Nothing very exciting has happened in that field. There has alway been a mystique about surgical procedures, gadgets, and gimmickry. The public has been willing to pay for those services because they seem dramatic. The insurance companies have gone along with that type of reimbursement because it's simple and clear-cut. An appendectomy, esophagoscopy, proctoscopy, or cardiac catheterization is an appendectomy, esophagoscopy, proctoscopy, or cardiac catheterization. Very clear-cut. But a physical examination is not. A physical examination is different to different people. All of you have about six different categories, and it's very hard to make a clear ruling as to what is a physical examination, so they've chosen to take the easy ones and that has made it more difficult.

Laboratory and radiology fees are believed by many people to be too high in proportion to services

> **"What is proper reimbursement?...In the future our fees are more and more going to be set by third-party carriers and governments...There are some areas that lend themselves to some degree of action if we are willing to take the necessary steps...we, as a profession, must stand together to present a solid front."**

rendered by the physician who lays on hands. As an obstetrician, I do a circumcision and get paid $40.00 for five minutes of my technical time and without very much tension. The pediatrician in our group, or family practitioner, is lucky to get $40.00 for taking care of that baby all the time it is in the hospital, talking to the parents about how to take care of it, and that's begrudged. It certainly is totally wrong, in my opinion.

A variation on this brings me back to what I mentioned before about the action of the House. What the House has said, in essence, is that an appendectomy should cost the same whether it is done in Milwaukee or in Stevens Point or in Spooner. And if not, why not?

We have to assume that it is the same operation done by a competent individual trained to do the job. In this day and age it is almost unthinkable that any hospital would allow a procedure of this type to be carried out by somebody not capable.

Secretary Percy in the Department of Health and Social Services at the state level has informed the State Medical Society of an intention to establish a statewide fee schedule by January 1982. This would replace the 13 different schedules now used in Wisconsin for Medicaid. The basic problem with this is that the government has always said the logical fee should be that which is charged in Spooner, assuming Spooner's fee is lower than Milwaukee, and we don't really have good evidence to prove that. That way of thinking has just made it unacceptable to the medical profession in the past and I think it still does, which means we have to negotiate something here.

> **"The image of medicine, particularly in the legislative arena, has improved remarkably in the past seven or eight years. . .one of the reasons for its success is the tremendous work done at the local level in the political field by the Auxiliary."**

I don't believe this problem is incapable of being solved. I understand that, regardless of what happens, many of you physicians in the state will be objecting to any change in the status quo. But we have already been served with notice that change is going to take place; and I think our chances of getting an acceptable solution or as close to an acceptable a solution as we can are going to depend upon our getting involved rather than waiting to see what they are going to impose upon us and then reacting.

We now see, in addition to the government and third-party carriers, a move by the big business organizations of this country to get into the health care cost issues. They can no longer afford to stay out of this process, and they intend and are getting involved. This means again that we, as a profession, must stand together to present a solid front.

We have to take a long, hard look at these money matters, and we should take and assume the leadership role as to where we go. This approach will reinforce our dealing with other organizations and the importance of keeping them as our allies and friends, particularly in such groups as the Auxiliary.

I want to close with just a personal note because I've had so many discussions about the HMO concept during my course of being the president of your Society. I consider the HMO issue to be, by far and away, the most devisive issue that this Society faces.

I rather suspect the statewide fee schedule will replace that, so next year the officers can worry about how they are going to handle that problem. But we've had in Marshfield a highly successful HMO operation for the past ten years, and I push repeatedly at the state level to talk about HMOs, because I get this devisive story from everybody.

I believe for some people in some places the HMO or the HMO-IPA movement is a very good approach, but I am becoming increasingly concerned about developments that I see coming in the State of Wisconsin.

The thrust of my discussion in the past, if you have really listened or read about what I've had to say, is that physicians should not get involved until they thoroughly understand the subject. My interpretation as to what is going on now is that many physicians are being stampeded by insurance companies into forming some sort of an HMO arrangement which is really just another form of an insurance program with the insurance company expecting to and calling the tune. The physicians become partners and find that they are supposed to do the policeman's job and also are at financial risk. And there is practically little or no return. I'm not pushing the HMO, I am just pushing physicians' understanding of what they are getting into, if they wish to get involved in this movement.

We, as a Society, have got to concentrate on our accomplishments rather than waste time talking about our apprehensions. We have to focus on our achievements rather than our fears. We have to get involved with friends such as the Auxiliary, and we have to become involved in financial discussions.

I would like to close by thanking all of the people who have worked with me. It has been a pleasant year. I particularly want to thank all the physicians in the House, the Council, and the staff of the State Medical Society. I am sure you can all look forward to excellent care in the next few years from the people who will be taking over the roles of the leadership of this group. ■

Post-annual meeting reflections (1981)

John P Mullooly, MD
Milwaukee, Wisconsin

AFTER FOUR bone-wearing days of Council meetings, commission and committee deliberations, caucuses, frustrations and joys of these days now behind us, it is time to reflect on some of the highlights and vignettes of this exciting meeting in Milwaukee in the silence of one's study.

Perhaps the most dramatic action of this convention was the action taken by the House of Delegates in which the unified membership rule was deleted from the Constitution. This issue had been coming up year after year and resulted in a "house divided." As we all know, steady pressure to do away with this requirement had been building for years.

DeLore Williams, MD—

I, too, will change my vote in order to comply with the will of the House

I would merely like to say that though I am an obstinate man, I certainly am not an unreasonable nor stupid man. When I gave my speech yesterday, I still hoped for a stronger division of the House in support of unified membership.

In view of the very close vote of yesterday;

In view of the fact that three presidents—past, present, and president-elect—spoke in favor of getting rid of unified membership;

In view of the very strong cases that were presented to me in the corridor last evening and this morning with respect to the urgency of this issue; many of those cases being made by people who are in local leadership and would be embarrassed by having to go back and report that we still had unified membership and by a very, very slim vote;

Knowing that there is perhaps a rising desire on the part of Wisconsin physicians to do away with unified membership;

Not wanting to frustrate the will of this House and now accepting within my own mind the fact that ultimately unified membership must die in Wisconsin;

Still expressing a very strong support for the AMA;

Still a little uncertain to where this course will take us,

I would like to say that I, too, would support reconsideration and will change my vote in order to comply with the will of the House. ■

Those forces for dropping unified membership in the AMA were a simple majority at last year's House of Delegates. In the second session of the House, Dr James Murphy of LaCrosse led the forces and was followed by the past president, president, and president-elect for doing away with unified membership. Dr DeLore Williams of West Allis, an AMA delegate, in an impassioned speech delivered in magnificent oratorical style, led the forces for retaining unified membership. Tensions rose high as a roll call vote was taken and once again the unified membership group won by two votes. The necessary two-thirds for repeal of this part of our Constitution was not obtained.

As the delegates broke up after the second session on Friday, the word went out that this matter would be brought back for reconsideration at the third session on Saturday morning. As the delegates reflected and discussed this Friday night, a most startling development occurred. Many delegates reflected, talked, and agonized. On Saturday morning after the 7:00 o'clock caucuses had broken up and we had registered, somewhat bleary-eyed and tired, for the 8:00 AM third session of the House of Delegates, portents of a dramatic turn of events were heralded when Dr Michael Mehr of Marshfield, Dr John Riesch of Menomonee Falls, and Dr Richard Shropshire of Madison rose to the microphone and declared that upon reflection they were going to switch their votes to do away with unified membership.

The highlight of the convention, however, occurred when the grand orator from West Allis took the floor and declared that he, too, in the interest of unity, after many years of impassioned clean fighting, was also going to withdraw his opposition and vote to do away with this requirement. Here was a man who articulated the issue so well and for so long in statesman-like fashion, giving up the fight in the interest of unifying this "house divided." The awed silence of this august assembly listening to Doctor Williams' incredible reversal was soon turned into vigorous applause. The leading protagonist garnered many friends and proved to be a healing influence upon this House of Delegates. The following vote was near unanimous in the voice ballot then taken.

The gratitude of the delegates to Dr DeLore Williams' change of stance was most evident as the delegates left the House, vowing to recruit all our disaffected colleagues who held up unified membership as a serious obstacle to joining the medical society. Hopefully, they will be successful in their efforts, and we all hope that many will voluntarily

join or retain their membership in the AMA. We are at a crossroads in organized medicine in the difficult days ahead and it is time for every physician who is not a member of the medical society to join his colleagues who have borne the heat and exertions of the day.

Another notable item on which to reflect is the membership of our three new alternate delegates to the American Medical Association who were elected at this Annual Meeting (terms to start in 1982). They are extremely able, articulate, intelligent physicians who will serve us well in the years ahead at the AMA sessions.

One is a neurologist, Dr Kenneth Viste, Oshkosh, chairman of the Physicians Alliance Commission. Doctor Viste's performance with the Alliance has been superb and he will bring to his new position a background of expertise in dealing with the Legislature and a knowledge and insight of political matters rarely to be found.

Dr J D Kabler, a university professor of medicine from Madison, who looks and talks like the white-haired senator from a midwestern state is the second one. He is an orator from the old school. Shrewdness of intellect, concern for patients, sensitivity to delicate issues, knowledge of university and legislative affairs, concern for the needs of nurses, vigor in debating controversial matters, and kindness in interpersonal relationships are his hallmarks.

The third is Dr Walter Woloschek, a vigorous, enthusiastic surgeon and immediate past president of the Medical Society of Milwaukee County, a man who did much to heal the rift between Milwaukee County and the State Medical Society, in whose presence the healing balm of his personality is most evident. His interest and attendance at national meetings of the AMA, his experience with local and state medical society affairs, and his ability to get along with diverse personalities are great assets which he will bring with him to this new post.

Certainly the most interesting and somewhat amusing thing about these conventions is the personalities involved and how they rise to the surface in debating and politicking. In the First District caucus and on the floor of the House, Dr Robert Purtell Jr, chairman of the caucus, and Dr John Riesch seemed to gather increased strength and vigor as they perceived threats, argued for positions, and motivated their delegates. As the heat of battle rose, their enthusiasm for the fight soared. To the more diffident, it was like an athlete or a soldier getting prepared for the contest or war.

I am sure that other caucuses were just as exciting as demonstrated by the performances in the House of Delegates. Men who come to mind include Doctors Richard Shropshire (Madison), Michael Mehr (Marshfield), James Mattson (Green Bay), James Murphy (LaCrosse), Charles Landis (Milwaukee), and Raymond Zastrow (Hartland). Dr Duane Taebel, internist from LaCrosse and speaker of the House, performed admirably, judicially with great prudence and judgment during these sessions, never losing his "cool" under the strain of it all. When difficult questions were posed for his ruling, he was invariably right on target and earned the gratitude and praise of us all.

As the convention broke up, it was evident that a great deal of business had been transacted, many policy decisions made, and many positions taken. Perhaps the best thing that occurred was the unification of our House of Delegates which can now proceed during the next year to take on the challenges facing medicine today from the public and from state and federal governments and bureaucracies.

Now that we have mended our differences, we shall work together for the health and welfare of the patients we serve and the society in which we live and from which we have been given our professional rights and prerogatives.

Advertising space available in the June BLUE BOOK issue

The annual BLUE BOOK issue of the *Wisconsin Medical Journal*—containing medicolegal, socioeconomic, legislative matters of direct concern to physicians in their relationships to patients, hospitals, government agencies, the Legislature, and others in the medical community—will be published in June. The *Wisconsin Medical Journal* welcomes the opportunity to provide advertising space to Society members, medical clinics, hospitals, and others involved in healthcare who desire to make their services known to the medical community. Advertisements will be accepted until June 1. Anyone wishing to participate may call the Journal office: 257-6781 (Madison area) or toll-free 1-800-362-9080 (in Wisconsin) for further details.

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Serum K^+ and BUN should be checked periodically (see Warnings).

ore prescribing, see complete prescribing information SK&F Co. literature or *PDR*. The following is a brief mary.

VARNING

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traindications: Further use in anuria, progressive renal epatic dysfunction, hyperkalemia. Pre-existing elevated m potassium. Hypersensitivity to either component or r sulfonamide-derived drugs.

nings: Do not use potassium supplements, dietary or rwise, unless hypokalemia develops or dietary intake otassium is markedly impaired. If supplementary potasn is needed, potassium tablets should not be used. erkalemia can occur, and has been associated with liac irregularities. It is more likely in the severely ill, with e volume less than one liter/day, the elderly and diabetics suspected or confirmed renal insufficiency. Periodically, K^+ levels should be determined. If hyperkalemia elops, substitute a thiazide alone, restrict K^+ intake. **ociated widened QRS complex or arrhythmia requires mpt additional therapy.** Thiazides cross the placental ier and appear in cord blood. Use in pregnancy requires ighing anticipated benefits against possible hazards, ding fetal or neonatal jaundice, thrombocytopenia, other erse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Dyazide should be withdrawn before conducting tests for parathyroid function.

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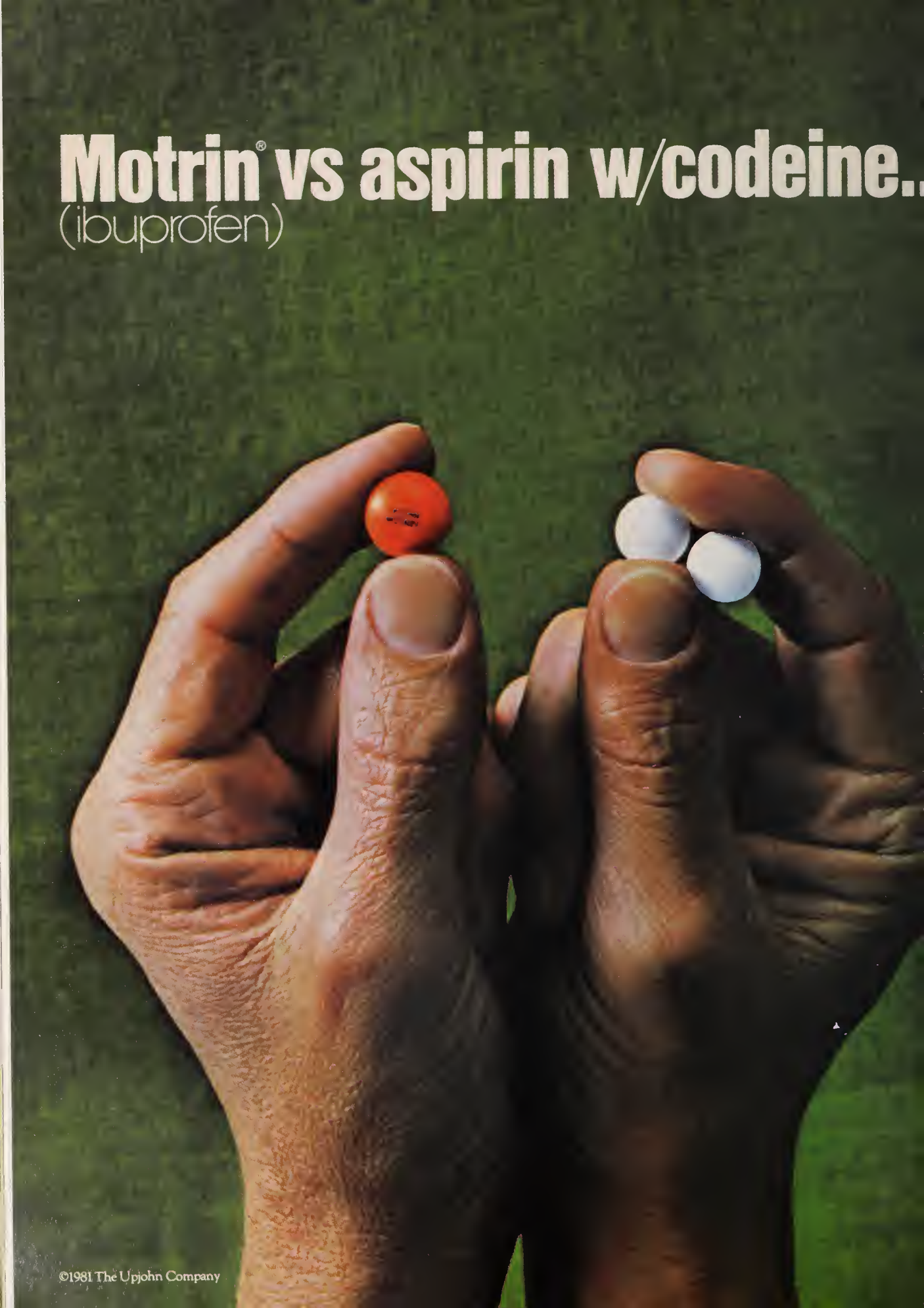

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A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
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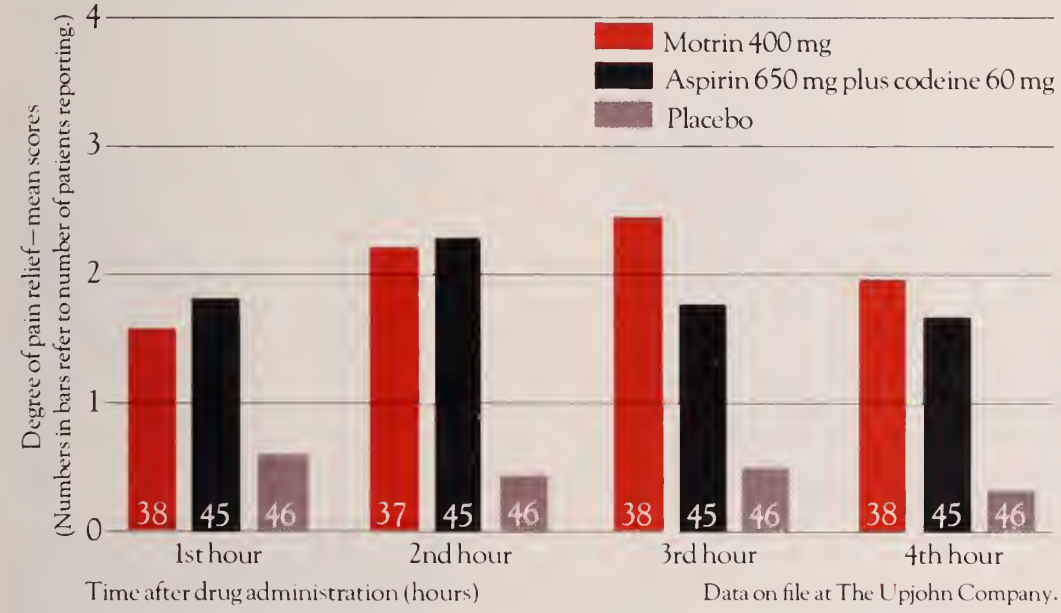

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Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

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Unified membership ends in Wisconsin

The SMS House of Delegates March 28 voted 109 to 9 to eliminate the concept of unified membership for Wisconsin physicians. Under the amendment to the SMS Constitution approved by the House, physicians now have the option of joining their county, state, and national societies, or just their county and state societies.

In making the change the House emphasized the great importance of continuing to join and support AMA as the most capable organization to represent physicians at the national level. Physicians may not join only the American Medical Association, since the AMA's Constitution and Bylaws require that it accept into membership only those physicians who are members of their state society.

This change became effective with the adjournment of the House of Delegates on March 28, 1981. ■

Council Award given to Doctor Lubitz

The highest honor of the State Medical Society of Wisconsin, the Council Award, was bestowed upon Joseph M Lubitz, MD of Oconomowoc, March 27, during the Presidents' Dinner at the Society's Annual Meeting in Milwaukee.

Doctor Lubitz, a pathologist, is the 45th recipient of the award which is given to those physicians who have "served with outstanding distinction the science of medicine, their fellow physicians, and the public." SMS Council Chairman Darold A Treffert, MD, Fond du Lac, presented the award on behalf of the Society.

A graduate of the University of Munich Medical School in 1936, Doctor Lubitz served in the US Public Health Service as a lieutenant from 1940 until 1946 when he joined the faculty of the Marquette University Medical School (now Medical College of Wisconsin) and became Chief of Laboratory Service at Veterans Hospital at Wood, Wisconsin. A great many of the pathologists in the state have trained under his tutelage.

Currently Director of the Laboratory at Oconomowoc Memorial Hospital and on the Board of Directors of both Sacred Heart and DePaul Rehabilitation hospitals in Milwaukee, Doctor Lubitz has shown outstanding leadership in the alcoholism field. Under his chairmanship in 1968, an advisory committee of physicians was successful in transforming DePaul Rehabilitation Hospital from a halfway house.

A former president of the Wisconsin Society of Pathologists, Doctor Lubitz is described by a colleague as "having a unique ability to bring differing factions of people together, help them resolve their differences, and move forward in a united effort."

He was called upon to play this role several times during his six years as chairman and 15 years as a member of the Society's Commission on Governmental Affairs. It was this dedication to the work of that commission which earned him the nickname "Mr Governmental Affairs."

In the early 1960s Doctor Lubitz chaired a citizen's committee that created the Brookfield-Elm Grove School System. He served for 14 years on the school board there as well as on several other community boards and commissions.

From 1977 to 1979 Doctor Lubitz served as chief of staff of Oconomowoc Memorial Hospital.

In presenting the award, Doctor Treffert said: "Joe has always brought a total dedication of himself to everything he does—be it medical politics, community or civic affairs, or teaching students the art and science of medicine. No matter what the issue, no matter what the obstacles, he has worked with one overriding concern in mind: the public's welfare." ■

DOCTOR LUBITZ

CBS newsman talks economics, TV news with doctors

"It's easier to predict the weather than to try to predict the final outcome of a tax bill," CBS business correspondent Ray Brady told physicians present March 27 for the 1981 Socio-Economic Luncheon.

Brady did predict, during his talk at the luncheon sponsored by WISPAC, that Congress would not go along with the three-year, ten percent tax cut plan of the Reagan administration.

"If we proceed with increased military spending with massive tax cuts, the net result will be a high inflationary combination," he said.

Don't look for much change in the interest rates, he said, and don't expect a large growth in the nation's economy.

Switching gears then to talk on how television covers the major socio-economic issues of the day, Brady con-

continued next page

Board of Directors action: March 25 & 28, 1981

The Board of Directors of the State Medical Society (formerly the Council) discussed a bill reportedly being proposed by chiropractic groups to require a hospital that provides outpatient x-ray or laboratory services on the referral of a staff member, to provide the same services on the referral of any licensed chiropractor. The Board voted to oppose this proposal if and when it is introduced in the Legislature. The Board did not feel the draft met the best interest of Wisconsin patients in providing quality healthcare.

In other actions the Board:

• Directed the SMS Committee on Mental Health to proceed with work on a redefinition of medical psychotherapy which clearly delineates that physician-performed psychotherapy is indeed different from psychotherapy performed by allied health practitioners. The SMS Committee believes mental health services rendered by physicians should be covered under the mandated services section of the Medical Assistance rule.

• Received a progress report from the Ad Hoc Committee on Health Practitioners on its work in reviewing the present Medical Practice Act and other statutes affecting health practitioners. The committee will be recommending policies for physicians and allied health professionals to follow in any shared responsibility for patient care.

• Agreed to extend for another year an agreement the Society has with the State Medical Examining Board to conduct a statewide Impaired Physician Program.

• Reelected Darold A Treffert, MD, Fond du Lac, chairman and Timothy T Flaherty, MD, Neenah, vice chairman of the Board of Directors for 1981-82. John J Foley, MD, Menomonee Falls, was elected treasurer and Richard W Edwards, MD, Richland Center, was elected assistant treasurer. Reelected as assistant treasurers were H K Tenney, MD, A A Quisling, MD, and Eugene J Nordby, MD, all of Madison.

• Reelected Wayne J Boulanger, MD, Milwaukee, as editorial director of the *Wisconsin Medical Journal.* Editorial associates appointed for 1981 are Raymond A McCormick, MD, DePere; John P Mullooly, MD, Milwaukee; Victor S Falk, MD, Edgerton; and Russell F Lewis, MD, Marshfield. ■

RAY BRADY

continued from preceding page

ceded that the relationship between television and the professions often has not been very good.

"People in the professions are best qualified to speak out, and there is a market of people who want to listen to what you say," Brady told the physicians in the audience. "And yet, you are too reticent to talk to news media on the very issues on which you're most qualified to speak."

"The opponents of all the things you stand for, the Kennedy's and the Metzenbaum's, have changed their side of an issue," he said.

Brady said the best way for physicians to get their story across was *not* to talk about their own problems, but rather, talk about "gut issues."

"Tell how something will affect people or patients, their health, or their pocket books," Brady explained.

He said physicians must get their message out via the media often and vigorously.

"You never know when this will help you in other circles to get your message across," he said. ■

Madison woman new president of Medical Society Auxiliary

Mrs Donald A Peterson (Audrey L) of Madison, was installed March 27 as President of the Auxiliary of the State Medical Society of Wisconsin at an inaugural luncheon at the Marc Plaza Hotel in Milwaukee.

Mrs Peterson, who served as president-elect for the past year, succeeds Mrs Glenn M Seager (Lila M) of Stoddard as president of the volunteer organization representing about 2,000 physician spouses in Wisconsin.

A graduate of Rockford College, Rockford, Illinois, Mrs Peterson also holds a Master of Science degree in cytology from the University of Iowa in Iowa City, Iowa.

She has spent several years in research activity, including serving as a research assistant at the Cardiovascular Lab at the University of Wisconsin Medical School for ten years.

A former president of the Dane County Medical Auxiliary, Mrs Peterson has held several other posts in the state and local auxiliary.

A member of the Board of Directors of the Visiting Nurse Service in Madison for seven years, Mrs Peterson is also a past president of the organization and is a member of the Attic Angels Association in Madison.

She has served as a volunteer coordinator and as chairman of the Advisory Board for Mobile Wheels in Madison and is active in the Parent-Teacher Association.

A sports enthusiast, Mrs Peterson currently is director of the Women's Western Golf Association and Foundation and is a former president of the Madison Toories, a women's curling group in Madison.

A mother of two daughters, Mrs Peterson is married to Donald A Peterson, MD, a Madison ophthalmologist. ■

STAFF PHOTOS BY KEN OPIN

Medical Museum opens May 1

The Medical Museum at Prairie du Chien May 1 reopened its doors for the 1981 season, the Charitable, Educational and Scientific Foundation of the State Medical Society has announced.

Located on the banks of the Mississippi River, this medical history-health education complex is built on the site of the old Fort Crawford. Dating back to 1826, the reconstructed military hospital at the fort today provides a setting for exhibits depicting 19th century medicine in Wisconsin including: the Indian Medicine Man and his herbal remedies, dioramas depicting the progress of surgery in this country, a replica of a Wisconsin physician's office of the 1850s, a reconstructed pharmacy of the 1890s, and an old time dental office.

Fort Crawford has international historic significance as it was here in the 1830s that Doctor William Beaumont, a military surgeon, conducted his pioneering studies on digestion. In fact, Doctor Beaumont's experiments on Alexis St Martin, "the man with a hole in his stomach," form the basis of our present day knowledge of the digestive system.

Another portion of the museum facility, the Stovall Hall of Health, houses a wide array of unique health education displays. Visitors to Stovall Hall will find health fads and fallacies; drug abuse; immunization and disease prevention, including an authentic "iron lung" used for polio treatment until the mid-1950s when the polio vaccine was developed.

A special attraction on the tour are the electronic "Transparent Twins." Life-size female models, the twins explain the organs and functions of the human body through light and sound.

New exhibits featured this year include a "Medical Hall of Fame"—a series of displays honoring Wisconsin physicians who have made outstanding contributions to medicine and health. The office of New Richmond physician, Doctor Frank W Epley, is recreated in this setting using actual windows and furnishings from the original office built in 1877. Doctor Epley was one of the first physicians in the midwest to do blood transfusions and appendectomies.

Other physicians whose stories are told here include Dr Nicholas Senn, Dr John B Murphy, Dr Laura J (Ross) Wolcott, and Dr Gunnar Gundersen.

For the art enthusiast, the Museum's administration building has on display seven medical still-life paintings by internationally reknown artist Aaron Bohrod. Done in Bohrod's famous "trompe l'oeil" (fool the eye) style, the paintings depict various disciplines of medicine such as pediatrics, cardiology, infectious diseases, and neurology-psychiatry.

Owned and operated by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, the Medical Museum will be open this year from May 1 through October 31 from 10 am to 5 pm daily. Admission is $1 for adults and 50 cents for children.

Tour guides are available for groups with advance reservations. To make a reservation, call or write: Medical Museum, 717 Beaumont Road, Prairie du Chien, WI 53821, phone: 608/326-6960. ■

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DOCTOR SUTHERLAND (right) receiving the Elvehjem Award from Joseph J Mazza, MD, president of the Wisconsin Society of Internal Medicine.

Doctor Sutherland speaks at Internal Medicine program

David Sutherland, MD, of the Department of Surgery at the University of Minnesota in Minneapolis, presented the 1981 Elvehjem Memorial Lecture March 28. Each year since 1962, the Elvehjem Lecture has been presented during the Internal Medicine meeting at the SMS Annual Meeting to honor the memory of Conrad A Elvehjem, PhD, the 13th President of the University of Wisconsin and an international authority in biochemistry.

Doctor Sutherland spoke on "The Current Status of Pancreas and Islet Transplantation for Diabetes" to the more than 150 physicians in attendance. ■

Houghton honors go to two outstanding students

One of the projects the Charitable, Educational, and Scientific Foundation of the State Medical Society takes the most pride in doing is bestowing the Doctor Houghton Award each year to two senior medical students in Wisconsin.

This year's recipients of the Houghton Award are Douglas Gentile of the Medical College of Wisconsin and Marc Williams of the University of Wisconsin Medical School.

Established in 1968 by the late John H Houghton, MD, the Houghton Award honors Wisconsin medical students "who through scholastic excellence, extracurricular achievement and interest in medical organization show high promise of becoming a complete physician."

CES Foundation President Robert T Cooney, MD, presented the award consisting of a check for $100 and a plaque to Marc Williams, March 26, during the first session of the House of Delegates in Milwaukee. Mr Gentile was unable to personally accept the award.

Mr Williams received his undergraduate degree from the University of Wisconsin-Madison, with a major

continued next page

AMA-ERF gives $21,043.81 to medical schools

Lila Seager, Stoddard, immediate past president of the SMS Auxiliary pesented checks totaling $21,043.81 on behalf of AMA-ERF to the associate deans representing Wisconsin's two medical schools, March 28, during the third session of the House of Delegates. Donald T Fullerton, MD, University of Wisconsin Medical School received $7,297.84 on behalf of his school and Paul S Rosenfeld, MD, Medical College of Wisconsin, received $13,745.97. ■

DOCTOR COONEY, MARC WILLIAMS

continued from preceding page

in chemistry. Upon his graduation from medical school this spring, he plans a residency in pediatrics.

A student member of the American Medical Association and of the American Academy of Family Physicians, Mr Williams received the Alvin Schultz Award at the University of Wisconsin Medical School in 1980 for his "sensitivity and compassion in dealing with a family and patient with a terminal illness." In 1978 he also served a summer externship in family practice.

In addition to his medical school activities, Mr Williams has been active in his church choir, church council, and other committees.

A native of Grabill, Indiana, Mr Gentile is the son of a physician. He attended Duke University in Durham, North Carolina before being accepted into medical school.

Mr Gentile has been active in a number of school activities throughout his four years of medical school. As a freshman he helped to revitalize the local chapter of the American Medical Student Association on the MCW campus, and was elected president of the chapter during his sophomore year.

In addition, he has served as his class's representative on the Faculty Assembly, and as chairman of the Student Affairs Committee. Mr Gentile has been active in the Peer Counseling Program at the Medical College. He was elected to Alpha Omega Alpha, the national medical honor society. ■

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New Fifty-Year Club members—1981

FIFTY-YEAR CLUB MEMBERS in attendance at the Annual Dinner of the 1981 Annual Meeting of the State Medical Society are shown above after receiving their awards. Front row, left to right: Carl G Dunst MD, Milwaukee; George H Lane MD, Milwaukee; Marcus K Mookerjee MD, Milwaukee; Alice D Watts MD, Oregon; Sylvester J Darling MD, Mequon; Richard G Edwards MD, Kewaskum; and Leif H Lokvam MD, Kenosha. Back row, left to right: Leland C Pomainville MD, Wisconsin Rapids; Horace J Hansen MD, Sheboygan Falls; William E Clark MD, Oshkosh; Meyer S Fox MD, Milwaukee; Albon W Overgard MD, Stanley; Alvin H Brusky MD, Green Bay; Robert F Purtell Sr MD, Milwaukee; Richard E Martin MD, Two Rivers; and Anthony S Kult MD, Wauwatosa.

Others who were inducted into the Fity-Year Club are: John L Armbruster MD, Milwaukee; William E Bargholtz MD, Ashland; Nathan E Bear MD, Monroe; Boris I Bender MD, Milwaukee; Hiram B Benjamin MD, Milwaukee; Nelson A Bonner MD, Pompano Beach, Florida; John A Booher MD, Franksville; Enoch B Brick MD, Wausau; Norbert F Dettmann MD, Largo, Florida; Edward Eisenberg MD, Milwaukee; Ely Epstein MD, Milwaukee; Albert P Graham MD, Largo, Florida; Abraham I Greenberg MD, Milwaukee; George J Gumerman MD, Prescott; Raymond J Henderson MD, Tomahawk; Paul J Lawrence MD, West Palm Beach, Florida; Alfred T Leininger MD, Green Lake; Thomas A Leonard Jr MD, Madison; Floyd L Litzen MD, Gresham; James V Meli MD, Naples, Florida; Christian F Midelfort MD, LaCrosse; Edwin O Niver MD, Waverly, Ohio; Clifford A Olson MD, Baldwin; George C Owen MD, Milwaukee; Ralph T Rank MD, Milwaukee; Glenway L Rothenmaier MD, Racine; Ronald W Steube MD, Naples, Florida; Joseph E Szymarek MD, Milwaukee; Gamber F Tegtmeyer MD, Milwaukee; and Earl B Williams MD, Oshkosh. (Staff photo by Ken Opin)■

DOCTOR GRIFFEN receiving the Beaumont Award from Leland C Pomainville, MD, treasurer of the CES Foundation.

Kentucky surgeon delivers Beaumont Lecture

The William Beaumont Lecture was established by the State Medical Society in 1957 to present to Society members distinguished medical scientists whose research and clinical experience may enrich the knowledge and skills of Wisconsin practitioners.

This year's lecture was presented by Ward O Griffen, MD, professor and chairman of the Department of Surgery, Albert B Chandler Medical Center, University of Kentucky, Lexington, Kentucky on the topic: "Gastric Secretion—From William Beaumont to the Present (Gastric Pouches I Have Known)."

About 200 physicians heard Doctor Griffen's presentation, March 28, during the Surgery meeting of the State Medical Society's Annual Meeting in Milwaukee.■

Join SMS now

In light of the recent change in membership policy allowing physicians to join their county, state, and national societies or just their county and state societies, physicians are encouraged to join organized medicine now.

The State Medical Society has undertaken an aggressive membership campaign to recruit new members and retain current ones. The goal as set forth by President Motzel is for 100 percent membership of all physicians in Wisconsin.

Regular membership dues are $380 for the State Medical Society of Wisconsin, $250 for the American Medical Association, and county society dues vary. There are, of course, other membership classifications and varying dues amounts and methods of payment.

Membership applications may be obtained by contacting county medical society secretaries (a list appeared in the January Membership Directory issue) or by calling the Membership Dept at the State Medical Society offices in Madison: 257-6781 or toll-free 1-800-362-9080.■

Utilization, coverage sources of Medicaid cost problem

The State Medical Society, April 17, charged that Medicaid was "out of control" in Wisconsin because of almost unlimited healthcare benefits to nearly ten percent of its population.

"Each of the more than 425,000 Medicaid recipients have far more in healthcare coverage than any person either in public or private employment," SMS Secretary Earl Thayer said in a news release issued by the Society. "In a generally inflationary economy, that much unlimited insurance protection would break the bank of private companies. It is, as predicted, doing the same to public coffers," he said.

Estimates released by the Legislative Fiscal Bureau, April 16, showed that the cost of Wisconsin's Medicaid Program would reach nearly $2 billion in 1981-83. The Bureau's report also cited total payments to physicians, hospitals, and dentists as being far ahead of last year. Thayer pointed out that while physician usage was up by 18%, doctors had no fee increases from Medicaid between July 1979 and February 1981. "In this fiscal year the increase has only been about 4.6 percent," he added.

Thayer warned that Medicaid costs will continue to increase until something is done to reduce the coverage and curb utilization. ■

1981-82 Legislative Directories—A handy reference now available

Copies of the new "1981-82 Legislative Directory" prepared by the Physicians Alliance Division of the State Medical Society are now available. The Directory provides the names, addresses and telephone numbers of the Wisconsin Congressional Delegation and State Assembly and Senate members for quick and easy access. Contact the SMS Physicians Alliance Office. ■

CAPITOL UPDATE

With daily floor sessions suspended for nearly two weeks, the Legislature's Joint Finance Committee has been working to prepare an alternative to the Governor's budget package. The Finance Committee uses a system of "discussion groups" to analyze the Governor's bill (AB 66) and to make formal recommmendations to the full committee. Thus far the Finance Committee has taken the following actions:

- Approved funding for the Appleton Family Practice Clinic.
- Rejected increased funding for the Department of Family Practice at UW and directed UW to prepare a report for 1983 outlining "programmatic changes" in family practice to allow it to live within its budget. The Department had originally requested $970,000 in additional funds, and motions to add $600,000 and $300,000 were defeated.
- Added language to require the State Laboratory of Hygiene to charge local units of government for tests performed for private individuals or those not a part of "the public health mission" of government.
- Added $1.3 million to the UW Medical School plus authority to the UW to adjust class size to fit the budget. The Governor had suggested the deletion of $1.6 million in *each year* to be made up through increased faculty contributions to the Clinical Practice Plan.
- Approved an 8% inflation increase to the per capita payments to the Medical College of Wisconsin. MCW had requested 9%.
- Restored $500,000 for family planning activities.
- Added funds for more investigators for the Department of Regulation and Licensing.

Still pending before the panel is the entire T-19 budget and the Governor's recommendation for a moratorium on hospital and nursing home construction. New Medicaid estimates suggest the program will reach over $1 billion during the current biennium, and the Dreyfus budget is anywhere from $60-$90 million short of a balance. T-19 is expected to be one of the last items considered by the committee. The budget committee is also expected to propose an alternative to the Dreyfus moratorium. The Governor has proposed that:

1. All hospital projects over $250,000 be "frozen" for an *indefinite* period.
2. During the moratorium, HSAs and the Division of Health develop areawide and statewide plans that identify what hospitals should be allowed to provide specific services, and secondly, a statewide capital expenditure limit for all hospital construction and renovation.
3. The June 30, 1982 "sunset law" on certificate-of-need be repealed. (While the Governor's proposal appears to be unacceptable to many legislators, it is clear that some moratorium system will be approved by the Finance Committee. The SMS Physicians Alliance has been discussing that alternative with Finance Committee members. A decision was expected in early May.) ■

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FWT-24 C-E-L

Obituaries

✓County, State, and AMA members

✓**John David Charles, MD,** 71, Fox Point, died Dec 5, 1980 in Milwaukee. Born Dec 27, 1980 in Menominee, Mich, Doctor Charles graduated from Marquette University School of Medicine and completed his internship and residency at Milwaukee County General Hospital. He served in the United States Navy from 1942-1946. Doctor Charles retired from medical practice in 1974.

✓**Syrene C Goldberg, MD,** 67, Milwaukee, died Feb 23, 1981 in Milwaukee. Born May 11, 1913 in Milwaukee, Doctor Goldberg graduated from Marquette University School of Medicine and served her residency at Mt Sinai Hospital, Milwaukee. She practiced allergy until 1960 when she entered a psychiatric residency at Milwaukee County General Hospital. Doctor Goldberg was a member of the medical staffs of Milwaukee County General Hospital, St Michael Hospital Mental Health Center, and the Kenosha Counseling and Psychiatric Clinic in addition to maintaining a private practice. Surviving are two sons, Steven of Kenosha, and David of Los Angeles, Calif.

✓**Stephen H Ambrose, MD,** 74, Whitewater, died Mar 21, 1981 in Whitewater. Born Apr 11, 1906 in Hudson, Ill, Doctor Ambrose graduated from the University of Illinois Medical School and served his internship and residency at St Luke's Hospital in Chicago. He served in the United States Navy from 1942-1946. Doctor Ambrose served on the Board of Regents of the University of Wisconsin and State Colleges from 1966-1972 and for 18 years was a part-time physician for students at Whitewater State University. The health center on the campus is named after him. He had practiced medicine in Whitewater since 1946. He also was medical director of the Fairhaven Home, Whitewater, and was a member of the Fort Atkinson Hospital medical staff. Surviving are three sons, Henry, Darien, Conn; Stephen, New Orleans, La, and William of Durham City, England.

✓**John J Rouse, MD,** 76, Reedsburg, died Mar 21, 1981 in Reedsburg. Born July 1, 1904 in Dana, Iowa, Doctor Rouse graduated from the University of Iowa Medical School and served his internship and residency at St Luke's Hospital, Duluth, Minn. He practiced medicine in Hillsboro from 1935-1942; served in the United States Army from 1942-1945; and had practiced in Reedsburg since his discharge from the Army in 1945. He was a member of the "50 Year" club of the State Medical Society of Wisconsin. Surviving are his widow, Holly; and a daughter, Sydney of Green Lake.

✓**Walter F Lappley, MD,** 75, Cross Plains, died Mar 20, 1981 in Madison. Born July 16, 1905 in Fitchburg, Doctor Lappley graduated from the University of Wisconsin Medical School, Madison, and served his internship at St Marys Hospital, Madison. He served in the United States Army Medical Corps from 1942-1945. Doctor Lappley retired in 1970 after serving Cross Plains and the surrounding area since 1941. Surviving are his widow, Gunhild; and two stepsons, Robert Sutter, Mansfield, Ohio, and Donald Sutter of Cross Plains. ■

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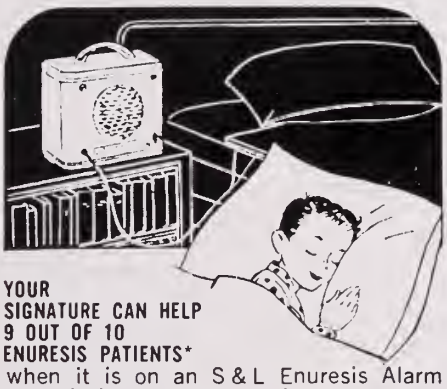

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Physician Briefs

*Physician members of State Medical Society of Wisconsin

Ruth Light, MD, Madison, has joined the medical staff of the Shearer-Cohen Clinic in Edgerton. A graduate from the University of California, San Francisco School of Medicine, Doctor Light will be associated with the Milton medical office of the Clinic. Her residency was completed at the University of Arizona Health Science Center and Tucson Hospital Medical Education Program.

Madhu Luthra, MD, Wausau, recently joined Merrill Medical Associates in the pediatrics Department. Doctor Luthra graduated from Lokmanya Tilak Municipal Medical College in Bombay, India. She served her residency in pediatrics at the University of Illinois Hospital, Chicago, and in general practice at Grant Hospital, Chicago. She also is a member of the medical staff of Holy Cross Hospital in Merrill.

Joseph L Skibba, MD* Robert E Condon, MD,* and **Frank E Jones, MD,** Milwaukee, have been awarded a three-year grant by the National Cancer Institute for research into the effects of hyperthermia and hyperthermia combined with chemotherapy on experimental liver tumors. Through use of an isolated perfusion technique, the physicians deliver heat just to the liver. Their results thus far have determined the threshold of heat tolerance by the liver tissue. The next step is to identify those drugs whose anti-cancer effects are enhanced by the heat.

John A McAuliffe, MD, Sauk Prairie, recently spoke on "Project Life" in New Holstein. Doctor McAuliffe designed "Project Life" while acting as the Surgeon General's consultant to the Department of the Army. The highly successful project resulted in the appearance of Doctor McAuliffe on educational television networks and also as the recipient of the "Investment in Tomorrow Award" of Blue Cross-Blue Shield United of Wisconsin.

David B Nelson, MD, Whitefish Bay, recently was awarded a five-year fellowship from the Milbank Memorial Fund to study epidemiology. An assistant professor of pediatrics at the Medical College of Wisconsin, Doctor Nelson will spend one year at the University of London School of Hygiene and Tropical Medicine working towards a master of science degree in epidemiology. The second year he will train in a clinical epidemiology unit at a teaching hospital in the United Kingdom. The remaining three years will be spent at Milwaukee Children's Hospital where he will develop teaching and research programs in epidemiology.

Harold Brooks, MD, Brookfield, recently was elected president of the professional staff of the Milwaukee County Medical Complex. Prior to joining MCMC, Doctor Brooks directed the Hans Hecht Hemodynamics Laboratories at the University of Chicago. He also will take on duties as a governor on the Wisconsin Affiliate of the American Heart Association Board of Governors.

Melvin F Huth, MD* Baraboo (left) is shown receiving the 1981 Distinguished Service Award from the Baraboo Jaycees president, Kirk Dempsey (right). Doctor Huth, who has been a member of the community since 1936, has participated in many civic organizations including his professional services at almost all area high school athletic events for 36 years. He presently is medical director at St Clare Hospital, and has served as Chief-of-Staff for three terms. (Photo by Curt Page Jr, *Baraboo News-Republic*)

Mary N Harkness, MD, Madison, recently became associated with the medical staff of the Sun Prairie Clinic. Doctor Harkness graduated from Washington University School of Medicine, St Louis, Mo, and completed her training in pediatrics at the District of Columbia Children's Hospital. She previously had lived in Miami, Fla, where her husband, Donald Harkness, MD, was a hematologist in the University of Miami Medical School. He has accepted a position as chairman of the University of Wisconsin Department of Medicine, Madison.

Donald J Miech, MD,* a Marshfield Clinic dermatologist, has successfully completed his board examination in dermatopathology.

Torrey L Mitchell, MD*, a pediatrician at the East Madison Clinic in Madison, has been named chairman of St Marys Hospital Medical Center's Infant Intensive Care Unit Committee. The committee, comprised of 21 physicians, nurses, and other professionals, reviews the operation of the IICU on a daily, weekly, and monthly basis. William H Bartlett, MD* served as committee chairman for several years prior to Doctor Mitchell's appointment. ■

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Wisconsin Surgical Society has elected Henry F Twelmeyer, MD,* Wauwatosa, to the office of president. Other MDs elected as officers are Thomas J Beno,* Green Bay, president-elect; and Richard B Windsor,* Sheboygan, secretary-treasurer. Folkert O Belzer,* Madison, and J David Lewis,* West Bend, were elected to the Council. New members elected to the Society are MDs James H Curl,* Green Bay; Paul S Fox,* Waukesha; Harold L Gerndt,* Manitowoc; Stephen C Jacobs, Milwaukee; Frank E Jones, Milwaukee; and Bahram Namdari,* Milwaukee.

American Academy of Orthopaedic Surgeons recently inducted Randall J Gall, MD* of LaCrosse as a Fellow. He is associated with the Gundersen Clinic Ltd—LaCrosse Lutheran Hospital.

American College of Chest Physicians recently elected Basil Varkey, MD of Brookfield as its governor for the state of Wisconsin. His term is for three years. Doctor Varkey is associate professor of medicine at the Medical College of Wisconsin, Milwaukee, and chief of the Pulmonary Disease Section at the Veterans Administration Medical Center, Wood.

Wisconsin Psychiatric Association recently elected the following physicians as its officers for the year 1981. They are MDs Jack D Edson,* Eau Claire, president; Richard Patterson,* Milwaukee, president-elect; George W Arndt,* Neenah, secretary; Robert F Goerke,* Milwaukee, treasurer; David Zarwell,* Milwaukee, councilor #1; and Edwin Sheldon, Jr* Madison, councilor #2. Due to a change in the Bylaws, the WPA for the first time used a general membership mail ballot. Ever since the election was founded, general officers were always elected at an Annual Membership Meeting. This year 312 ballots were mailed to all members of the WPA and there was a 53% return by the deadline date.

American College of Cardiology has elected D Joseph Freeman, MD,* Wausau, to serve a three-year term on the Board of Governors of the 11,000 membership. Doctor Freeman will provide liaison between the membership in the geographic area in which he lives and the Bethesda, Md, based national organization. He was one of 19 specialists around the country to be elected.

Recently elected to membership in the ACC are Carolyn C Goren, MD* and Alan A Gabster, MD* of the Gundersen Clinic Ltd, LaCrosse. The cardiologists are graduates of the University of California, Los Angeles and the University of Southern California School of Medicine. They joined the medical staff in 1980.

Melvin S Blumenthal, MD* of Monroe was recently elected to fellowship in the ACC. He has been associated with the medical staff of The Monroe Clinic since 1975.

American College of Surgeons will hold its 67th annual Clinical Congress in San Francisco, October 11-16. It is anticipated that over 13,000 physicians will register for the Congress, with total attendance, including guests and other medical professionals, exceeding 20,000. The College reports that this is the largest convention of surgeons in the world. Co-headquarters for the Congress will be the Fairmont Hotel and the San Francisco Hilton Hotel. Registration at the Clinical Congress is free for Fellows of the College whose dues are paid for 1980, and for Initiates and participants in the Candidate group. Registration fee for non-Fellows is $200. Surgical residents, with a letter verifying their residency status, pay $100. As an organization accredited for continuing medical education by the Accreditation Council for Continuing Medical Education, the American College of Surgeons designates that this continuing medical education offering meets the criteria for hour-for-hour credit in Category 1 as outlined by the above accrediting agency. Info: Dianne Currie O'Rourke, Manager of Public Information, ACS, 55 East Erie St, Chicago, Ill 60611 (ph 312/664-4050, ext 324).

American Board of Internal Medicine recently announced the certification of Les Harrison, MD and Steven Paulson, MD of Chippewa Falls. They have been members of St Joseph's Hospital medical staff since 1980. They graduated from the University of North Dakota Medical School in 1977 and completed three-year residencies at the University of North Dakota Affiliated Hospitals. ■

International Physicians awarded $100,000 grant

The Educational Commission for Foreign Medical Graduates (ECFGM) recently awarded the American College of International Physicians (ACIP) a grant of $100,000 to conduct a series of FMG National Leadership Development Conferences to be held nationwide in major cities with large concentrations of FMGs.

With the recent AMA House of Delegates approval of a policy to give FMGs representation in the different councils, committees, and policy-making bodies of the AMA, these leadership conferences will help to identify motivated and interested physicians who can participate in the decision-making and policy-making processes at national, state, and local levels.

The ACIP is interested in reaching out to all persons, FMGs, physicians, and organizations who may wish to participate or join in these conferences, either as speakers, participants, or coordinators, in order to make these conferences more meaningful and productive for all FMGs.

All officers and members of ethnic FMG organizations or alumni organizations of medical schools abroad, are being requested to communicate any suggestions or requests for information that they may have to the ACIP Executive Director at 3030 Lake Avenue, Fort Wayne, Indiana 46805; telephone 219/424-7414.

Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

If you examine and evaluate me in the light of your own experience, you'll come away with a confirmation of your knowledge that I *am* a safe and effective drug when prescribed judiciously and used wisely.

For a brief summary of product information on Valium (diazepam/Roche) ℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® IV
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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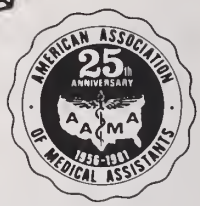

WISCONSIN TO HOST NATIONAL MEETING

June S Hirsch, CMA-AC

APPROXIMATELY 1000 medical assistants, educators, and students will be attending the 25th Annual Meeting of the American Association of Medical Assistants Inc to be held September 19-26, 1981 at the Hyatt Regency Hotel in Milwaukee. Wisconsin is particularly proud to host this Silver Jubilee Anniversary meeting, since the organizational meeting was held in Milwaukee in 1956. With 25 years of Service and Education, the Association is looking forward to continued growth and progress with the convention theme: *Today's silver—Tomorrow's gold.*

There will be many interesting educational sessions and workshops throughout the week, along with organizational information and meetings. Between times there will be exhibits from many professional groups to visit, and the Arts and Crafts from many members to view. A Welcome Party will be held on Sunday evening, September 20, to share a bit of Wisconsin "gemutlichkeit" in a beer garden atmosphere. On Monday evening the official convention will begin with the opening session of the House of Delegates. Tuesday and Thursday evenings are open to allow time to explore Milwaukee's ethnic restaurants. At a formal dinner Wednesday evening, certification pins and certificates will be awarded to those who successfully completed the national Certification Examination this past year.

The many activities of the week will culminate in the Inaugural Banquet on Friday, September 25, when presidents of all the state societies are introduced in the Parade of Presidents, highlights of the past 25 years will be reviewed, and new officers will be installed—all in *Reflections in silver,* the decor of the evening.

General Chairman, Alice Budny, and Vice Chairmen Carol Jean Beaver, RT and Dolores Conlon join the other members of the Wisconsin Society in

their pride in Wisconsin. We are all anxious to share our heritage with members of the American Association of Medical Assistants Inc from the other 49 organized states.

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SERVING SOUTHERN-CENTRAL WISCONSIN

Wisconsin State Medical Golf Association's spring meeting will be held Tuesday, June 2, at the South Hills Country Club, Fond du Lac, with teeoff time starting at 9 am and continuing until 1 pm. To register or indicate a desire to attend call or write: Ronald Oschman, Secretary, WSMGA, 401 West Michigan St, Milwaukee, Wis 53201 (ph 414/226-6151).

Western Wisconsin Emergency Medical Services Systems, Inc, has appointed the following physicians to review emergency medical services. They are MDs Philip Winskunas, Chippewa Falls, trauma consultant; Robert A Narotzky,* Eau Claire, spinal cord consultant; William C Boyd,* LaCrosse, burn consultant; Daniel T Kincaid,* Eau Claire, cardiac consultant; Michael Hartigan, LaCrosse, high-risk infant consultant; William Carskadon, LaCrosse, poison consultant; Joseph M Tobin,* Eau Claire, behavioral consultant. WWEMSS was formed by the Western Wisconsin Health Systems Agency in September 1980 under the provisions of Public Law 93.54, the Emergency Medical Systems Act. The purpose of the organization is to improve emergency medical services in western Wisconsin.

St Clare Hospital, Monroe, has named the following MDs to head its medical staff for 1981. They are Robert E Hassler,* president; William L Baker,* president-elect; and George E Breadon,* secretary-treasurer. Doctor Hassler succeeds John M Irvin, MD* as president.

St Luke's Hospital, Milwaukee, recently reelected the following physicians to head its medical staff. They are MDs Henry H Gale,* Milwaukee, president and Gerald L Schmitz, Brookfield, secretary-treasurer who were reelected for one-year terms. Reelected to two-year terms to serve as department chiefs are MDs Warren C Bogle,* Brookfield, anesthesia; Salvatore Fricano,* Brookfield, internal medicine; Henry H Gale,* Milwaukee, cardiology; and James R Nellen,* Greendale, radiology. Newly elected are MDs Ik H Bae,* obstetrics and gynecology; Robert S Chudnow,* Greenfield, family practice; and Charles A Wunsch,* psychiatry.

Milwaukee Medical Clinic recently announced the following officers of its medical staff. They are MDs Walton D Thomas,* chairman; Eugene W Monroe, president; and Robert J Santilli, medical director. Doctor Thomas is head of the clinic's surgery department; Doctor Monroe is head of the dermatology department; and Doctor Santelli has been a member of the internal medicine department since 1972. ■

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Physicians Exchange

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Full Time Faculty Position—Assistant Director of the sixth and newest Family Practice Residency Program of The Medical College of Wisconsin. Potential to become associate director, dependent upon qualifications. Faculty appointment to the highly successful Department of Family Practice of The Medical College of Wisconsin. Opportunity to participate in the formulation of a new program; residents to begin training July 1981. Outstanding Family Practice Center facilities. Candidate must be Board certified or Board eligible in Family Practice. Located in Southeastern corner of Wisconsin; 45 minutes from Milwaukee; 60 minutes for Chicago. Faculty rank and salary are negotiable, dependent upon qualifications and experience. Many fringe benefits. Send curriculum vitae and references to: RG Burnett, MD, Program Director, Southeast Family Practice Residency Program of The Medical College of Wisconsin, Tallent Hall, University of Wisconsin-Parkside, PO Box 598, Kenosha, Wis 53141. The Medical College of Wisconsin is an Equal Opportunity/Affirmative Action Employer. p4-5/81

General Surgeon, Board certified or eligible to join 8-man, multispecialty group on shores of Lake Michigan in picturesque Northeastern Wisconsin. Excellent 89-bed hospital two blocks from modern clinic. Call coverage available. Position available now. Contact Robert E Myers, MD, Doctors Clinic, Ltd, 2219 Garfield St, Two Rivers, Wis 54241; phone 414/793-2281. 4-5/81

Racine Medical Clinic, multispecialty group of 22 physicians has a practice association for internist. The clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406. Phone 414/886-5000. 5tfn/81

Wanted. Partner for partner, generalist-internist for internist-surgeon team. Surgeon will give up general practice but remain on call. Clinic, small hospital combination, no OB. Rural setting, 15 miles from larger city. Phone 608/854-2231. 5-7/81

Wisconsin, Oshkosh. Career emergency physician with residency training and/or experience as emergency physician. Well-established, fee-for-service corporation. Active community hospital with brand new physical facilities. Only hospital in town of 55,000. Excellent staff backup, paramedic program telemetry. Flexible scheduling, competitive salary. Fringes: funded CME, generous health and disability insurance allowance, corporate-paid retirement plan, one month vacation, paid malpractice. ACLS certification required. Send complete CVA: T M Loescher, MD, 2520 Crestview Dr, Appleton, Wis 54911. 5-6/81

Duke trained general psychiatrist with strong interest in psychotherapy wishes to relocate in midwest (Wisconsin). Now completing board certification. Contact James L Gallagher, MD, 2219 Mont Haven Dr, Durham, NC 27712. Phone 919/383-4477 (home); 919/417-3487 (office). 5-7/81

Emergency Medicine Opportunities. Directorship and clinical positions available in the greater Milwaukee area. Excellent income, paid malpractice insurance, and flexible scheduling provided. For details, send credentials in confidence to Michelle Grimm, 970 Executive Parkway, St Louis, MO 63141; or call toll-free 1/800/325-3982. 5-7/81

Board certified or eligible family practitioners, OB-GYN and surgeon wanted to join expanding multispecialty group located in South Central Wisconsin near major metropolitan area. Excellent salary structure and benefits first year with options thereafter. Interested physicians inquire immediately. All requests to be answered immediately and in confidence. Write Dept 488 in care of the Journal. 5tfn/81

Initial practice or relocation possibilities in central Wisconsin for independent gastroenterologists and pediatricians. Facilities available in new professional building located across from major medical complex. Personally tailored finished space. Support from established physicians. Contact: Wergin Realty, Inc, 2800 Westhill Dr, Wausau 54401. Phone: 715/848-1344. 5-8/81

Opportunity for Ophthalmologist. Board eligible or board certified ophthalmologist to join 49-man multispecialty practice in southern Wisconsin. Close to University Centers. Competitive income. Contact R E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566 or phone 608/328-7000. 5-6/81

Wisconsin—26 physician incorporated multispecialty group on the south shore of Lake Winnebago needs a fourth pediatrician. Guaranteed salary with full shareholder status available after one year. Send CV to Kirk A Veit, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. p5-7/81

Internist wanted to join a 14-physician multispecialty group in one of northern Wisconsin's finest recreation areas. Modern 109-bed hospital. Excellent professional and personal opportunity. Contact Dr J Wiesner, Lakeland Medical Associates Ltd, Box 549, Woodruff, Wis 54568 or call 715/356-3292. 5tfn/81

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Physicians Exchange

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Orthopedic Surgeon wanted to join orthopedic surgeon who has been in practice in Wisconsin Rapids since 1967. Excellent professional opportunity. Very competitive first-year salary and optional second-year corporate stockholder. Complete benefit package includes company-owned car. Call Tom Campbell collect at 414/255-6500 or send curriculum vitae to Orthopaedic Surgery Clinic of Wisconsin Rapids, 420 Dewey St, PO Box 1265, Wisconsin Rapids, Wis 54494. 4-5/81

Wanted Internist or Family Practitioner to share space in new office building with pediatrician in Madison area. Contact Mike McCann, MD, phone 608/831-7170. 5-6/81

Fifty-physician multispecialty clinic in West Central Wisconsin wants allergist, cardiologist (noninvasive), neonatologist, orthopedic surgeon, otolaryngologist, and family practitioner for nearby satellite office. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or phone 715/839-5266. 4-6/81

Family Physician to join two Board certified family physicians and one physician's assistant in a young and growing medical practice in Central Minnesota. The practice is oriented towards family medicine. The practice is located centrally in the state with quick access to Minneapolis/St Paul. Cultural and recreational activities are in abundance in this area of Minnesota. Salary open: Contact Daryl G Mathews, Admin, or Thomas J Newton, MD at the Cold Spring Medical Clinic, 26 N Red River Ave, Cold Spring, Minn 56320. Phone 612/685-8641. 4-6/81

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Physician—University of Wisconsin-Stout: Seeking physician for the Student Health Center which offers outpatient care to 7,000 students. License or eligibility to practice in Wisconsin required. Position entails primary care and coordination of activities of the Center in cooperation with the Administrative Director. Beginning date—August 15, 1981. Salary negotiable. Liberal fringe benefits including malpractice insurance. Contact: Dr Joseph M Larkin, Associate Dean of Students, University of Wisconsin-Stout, 303 Administration Building, Menomonie, Wis 54751. Phone 715/232-1436. 4-5/81

Emergency Physician: Southeastern Wisconsin, begin July 1981. Flexible schedule and excellent salary are guaranteed. Send CV to: Associated E R Physicians, 1131 Sherwood Lane, Caledonia, Wis 53108; ph 414/835-4889. 3-5/81

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

California. Anesthesiologist wanted in Northern California fee-for-service practice located in Marysville. Area is within easy driving distance of Lake Tahoe, ski and recreation areas, Sacramento and the San Francisco Bay Area. Great year-round climate with still reasonably priced homes. Modern, progressive, well-equipped hospital with growing medical staff. Attractive relocation incentive. Contact Judy Neal, 440 Grand Ave, Suite 500, Oakland, Calif 94610. Phone 415/832-6400. g5/81

Two Family Practice Physicians sought to assume a fully operational practice in a community 30 miles north of Madison, Wisconsin. New clinic facility. Income guaranteed. Physician back-up available. Board certified or eligible preferred. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 5tfn/81

Family Practice Physician sought for affluent small town with excellent social, retail, and educational resources. Easy access to year-round outdoor activities and to Chicago and Rockford for social and professional opportunities. For the family man with ambition for a successful practice.

Contact: Harvey Pettry, Administrator
Highland Hospital
1625 S State St
Belvidere, IL 61008
815/547-5441 3-5/81

Family Practice opportunities in outstanding Southern Minnesota group. The Albert Lea Clinic, PA, is interested in contacting physician candidates for city and small town branch practices. This group is a 16-man multispecialty group in the primary and secondary care fields. Top salary first year. Senior physician participation beginning at the end of the first year, an incentive income distribution plan. Low cost buy-in. Maximum profit-sharing plan. Top level insurance plan and full range of other benefits. New hospital in city. Albert Lea is an exceptional place to live and these are choice practices. Please contact B J Boss, Administrator, Albert Lea Clinic, PA, 1602 Fountain St, Albert Lea, Minn 56007. Phone 507/373-8251, personal phone 507/377-1406 or contact T F Thompson, MD, 507/373-8251, personal phone 507/373-0259. 4-5/81

Opportunity for Neurologist. Board eligible or board certified neurologist to join 46-man multispecialty practice in Southern Wisconsin. Close to University Centers. Competitive income. Contact R E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566 or phone 608/328-7000. 4-5/81

Wanted. Board certified or eligible oncologist to practice in conjunction with an 8-member medical department in a 22-member multispecialty group. Present sub-specialties: gastroenterology and cardiology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Family Practitioners for Rural Practice. One, but preferably two, family practitioner needed to serve an area of approximately 8,000 in Central Wisconsin. Clinic affiliation or private practice available. Salary guarantee possible. Close to excellent 181-bed fully accredited hospital. Send CV or contact Anton Omernik, Chairman, Recruiting Committee, 46 County A, Rosholt, Wis 54473. Phone 715/677-4761. p4-6/81

Family Physician. Four-man family practice group seeking fifth to assume established practice. Northern Wisconsin community of 8,000 with primary service area of 50,000. Excellent outdoor recreation opportunities. 80-bed hospital with full-time emergency room coverage. Competitive salary and fringes. Contact: Marsh Clinic, SC, 610 W Green Bay St, Shawano, Wis 54166. Ph 715/526-3137. p3-5/81

The Nicolet Clinic, SC, a young progressive 33 physician multispecialty group, has superb opportunities available for the practice of:

- Family Practice
- Thoracic Surgery

Ideal family oriented community in metropolitan area with excellent schools, economy, culture, and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued medical education. Contact in confidence Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Phone: 414/727-4244. 3-6/81

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Marshfield Clinic would like to hire locum tenens for anesthesia. Wisconsin license required. Please send curriculum vitae to Sidney E Johnson, MD, Medical Director, Marshfield Clinic, 1000 North Ave, Marshfield, Wis 54449 or call collect at 715/387-5253. 5-6/81

FAMILY PRACTICE OR INTERNAL MEDICINE PRACTITIONER—Team Practice In Madison with Staff Model Health Maintenance Organization

Very attractive working environment, predictable hours, close to University of Wisconsin Medical Center. Physician staff compensation package includes excellent salary, pension program, and full benefit coverage. For more information, call *F Manalo, MD, at 608/257-9700,* or send vitae to: *GHC, One South Park St, Madison, Wis 53715.* 4-6/81

Family Practice. Physician needed to join three Board certified family practitioners and one general surgeon. New clinic building adjacent to hospital in beautiful northwestern Wisconsin. Call is shared with other family practitioners in community. Contact Jean Chamberlain, Administrator, Spooner Clinic Ltd, 707 Ash, Spooner, Wis 54801. Phone 715/635-2151. 5-7/81

Locum Tenens work wanted. The more you know about choices, the easier it is to choose. That's why CompHealth, the oldest, largest locum tenens organization in the United States, can help make choices easier for you. Any specialty can be covered including FP, IM, Rad, Anes, and OB/GYN. With a large selection of reliable, qualified physicians to choose from, CompHealth provides physicians, hospitals, clinics and communities with dependable locum tenens coverage, allowing you to keep your practice covered without inconvenience or concern. Turn a difficult decision into an easy choice. Contact CompHealth, 175 West 200 South, Suite 2003, Salt Lake City, UT 84101; ph 801/532-1200. 3-5/81

Position now available in the Department of Internal Medicine for physician with subspecialty interest. Fifty-person multispecialty clinic in ideal location in Southern Wisconsin. Contact R E Hassler, MD, The Monroe Clinic, Monroe, WI 53566; ph 608/328-7000. 5-7/81

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Hematology/Oncology
- Family Practice
- Otolaryngology

Beautiful new building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

Opportunity for qualified physician in Internal Medicine in a two-man general internal medicine department in Southern Minnesota. The Albert Lea Clinic, PA, is a 16-man multispecialty group in primary and secondary care fields. Financial rewards are exceptional and practice challenges very attractive. Negotiated top salary first year. Senior physician participation beginning at the end of the first year and incentive income distribution plan. The clinic has a low cost buy-in with a maximum profit-sharing plan. There is a top-level insurance program, medical reimbursement program, and a full range of other benefits. A nearly new hospital in the city provides an exceptional place to work. This is a choice practice in an exceptional place to live. Please contact B J Boss, Administrator, Albert Lea Clinic, PA, 1602 Fountain St, Albert Lea, Minn 56007. Phone 507/373-8251. Personal phone 507/377-1406 or contact L E Shelhamer, Jr, MD, 507/373-8251 or personal phone 507/377-1530. 4-5/81

Physicians Exchange

continued

Orthopedic surgeon wanted to join a primary care/specialty group of 11 physicians in northwestern Wisconsin. Attractive family/recreational area 45 minutes from Twin Cities. Minimum salary guaranteed first year. Contact Tom Halverson, Clinic Manager, St Croix Falls Clinic, Box 739, St Croix Falls, Wis 54024. Phone 715/483-3221. 8tfn/80

Family Practice. General Clinic—Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 23-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 2tfn/81

Family or general practice. Small clinic in Northwest Wisconsin recruiting family or general practitioner. Rural area. Thirty or more lakes within 10 miles offer fishing, boating. Excellent opportunity for physician who desires outdoor activities, small town lifestyle. Clinic, all equipment and supplies, plus support staff, provided for use at no cost. Hospital approximately 21 miles. Salary, plus generous benefits, or net income split possible. Send resume to Glen Safford, NWMC, Box 86, Minong, WI 54859 (715/466-2201). EOE, M/F. 5/81

Allied Health

Physician Assistant seeks relocation. Have national and Wisconsin state certification. Experience in rural primary care, highly motivated and energetic. Prefer small community or rural family practice clinic especially in northern Wisconsin, upper Michigan. Resume and references upon request. Contact Dept 492 in care of the Journal. 5/81

Position wanted: Adult nurse practitioner, Master's prepared ANA certified practitioner wishes to work with family physician or general internist. Skilled in assessment and evaluation, management of acute and chronic health problems, health maintenance and teaching, and counseling. Interested in older adult population. Wishes to relocate in other than metropolitan setting. Contact Dept 491 in care of the Journal. 5/81

Medical Facilities

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

FOR RENT office space Greater Milwaukee area. 750-1500 sq ft in prestigious 3-year-old medical building located on Northridge Lakes (7400 West Brown Deer Road) only minutes from Northridge. Opportunity for medical group, specialist, or satellite office. Will remodel to suit. Please call area code 414/354-1160. 12tfn/80

Ritter ENT Unit. Includes motorized chair, service unit with air and suction and cautery and air pump. Also sterilizer with cabinet available. Good condition. Reasonable. PO Box 325, Stevens Point, Wis 54481. Phone: 715/341-2020. 2tfn/81

Available immediately. Solo family practice opportunity. Good growth potential in Fitchburg, the most rapidly developing area in Madison. For details contact M Gordon, MD, 2934 Fish Hatchery Rd, Madison, Wis 53713. Phone 608/273-1055. p4-6/81

Practice for sale. General surgery, northwest side Milwaukee, Wis. Write to Dept 490 in care of the Journal or call 414/258-7733. 4-5/81

Real Estate

Elkhart Lake—2 bedroom rental condo on beautiful Elkhart Lake, furnished, 2½ baths, tennis, golf, 2 miles from Road America. Available May-Oct, day, week, month. $350/week. D Opel, MD, 1330 N 5th St, Sheboygan, Wis 53081; ph 414/458-4522. p3-5/81

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Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1980 through Aug 31, 1981.

WISCONSIN

JUNE 4-6, 1981: *Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias,* The Performing Arts, Milwaukee. Approved 18 credit hours of Category I of PRA-AMA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706. Phone: 608/263-2856.

JUNE 11-12, 1981: *Neurological Intensive Care Symposium,* Wisconsin Center, Madison, Wis. Sponsored by Continuing Medical Education, University of Wisconsin-Extension, and Division of Neurological Surgery, School of Medicine, University of Wisconsin, Madison. Approved 17 hours AMA Category I; 1.7 continuing education units, University of Wisconsin-Extension. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, 608/263-2856.

JUNE 25-27, 1981: Annual Meeting of the Wisconsin Academy of Family Physicians, Hyatt Regency Hotel, Milwaukee. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

JUNE 27-JULY 11, 1981: *Scandinavian Holiday,* sponsored by the State Medical Society of Wisconsin. Cost: $1,998, round trip Milwaukee or Madison to New York to Copenhagen with return from Stockholm via Northwest Orient Airlines. Reserve space for $150 and final payment due on April 15, 1981. Info: Dittmann Tours, Inc, PO Box 199, Northfield, MN 55057, or contact Lee Johnson, SMS, toll-free 1-800-362-9080.

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ADMINISTRATIVE MEDICINE PROGRAM
will present a CME Category 1 credit course on

Communication of Health/Policy Information by Clinician Executives

Friday, May 29 and June 5, 7:00-9:00 pm
Saturday, May 30 and June 6, 9:00 am-12:00 noon and 1:00-4:00 pm
on UW-Madison Campus

Instructor: Jeffrey Kunz, MD, senior editor of *JAMA* in Chicago and UW-Madison Medical School alumnus.

Course will cover methods for establishing good relations with the news media, especially techniques for distributing and controlling publication of technical, controversial, clinician-executive's organization.

Info: Administrative Medicine Program, University of Wisconsin-Madison, 1225 Obervatory Dr, Madison, Wis 53706. Phone: 608/263-4889.

JULY 17-19, 1981: Clinical Management of Coronary Disease and Exercise Testing, Lake Geneva—The Abbey. Approved for Category I credit by AMA; prescribed credit by Wisconsin Academy of Family Physicians. Info: Director, CME, International Medical Education Corp, 64 Inverness Drive East, Englewood, Colo 80112 (ph 1-800-525-8646, ext 105).
5-6/81

JULY 24-25, 1981: *Current Emergency Care Problems,* Wisconsin Center, Madison. Sponsors: University of Wisconsin Emergency Medical Services Program; US Dept of the Army, Office of the Surgeon General; and UW-Extension, Dept of Continuing Medical Education. Audience: All physicians, nurses, and allied health professionals who deal with emergency care. Credit: 11 hours AMA Category I; Family Practice credit pending; American College of Emergency Physicians credit pending; AOA credit pending; 11 hours University of Wisconsin Continuing Education credit. Highlights: Program designed to allow rapid review of the subject with both structured plenary sessions and open discussion time with the faculty. Second day is devoted to hands-on workshops, insuring your practical involvement. Fee: $110 physicians; $85 nurses, residents, allied health professionals. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706 (ph 608/263-2856).

AUGUST 2-7, 1981: *Perspectives in Anesthesiology,* Tucson Hospital Education Program, The Abbey on Lake Geneva, Fontana.

AUGUST 24-25, 1981: *Uses and Abuses of Antibiotics in Clinical Practice,* Heidel House Resort, Green Lake. Sponsored by Berlin Memorial Hospital. Info: Linda E Nevers, CME Coordinator, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, Wis 54923. Phone: 414/361-1313.

SEPTEMBER 18-20, 1981: Fall Meeting, Wisconsin Society of Anesthesiologists, Lake Lawn Lodge, Delavan.

OCTOBER 14-17, 1981: *Wellness and Cardiovascular Health Symposium,* in celebration of the 10th anniversary of the LaCrosse Exercise Program. Involving: Adult Fitness, Patient Education, School Fitness, Exercise Testing, Community Fitness, Cardiac Rehabilitation, Exercise Physiology, Industrial Fitness, Sports Medicine, and Wellness. Inquiries: LaCrosse Exercise Program-Workshop Unit, Mitchell Hall, UW-L, LaCrosse, Wis 54601 (ph 608/785-8686).

MIDWEST

JUNE 4-6, 1981 (Illinois): *Panoramic View of Flexible Bronchoscopy Today,* Chicago, Ill. Sponsored by the American College of Chest Physicians with the Rush-Presbyterian-St Luke's Medical Center. Approved 16 credit hours of Category I of AMA-PRA. Info: Department of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, IL 60068.
4-5/81

JUNE 5-6, 1981 (Illinois): *Mental Disability Law and the Family,* a national conference of the legal and mental health professions, sponsored by the American Bar Association-Family Law Section. In recognition of the United Nations' "International Year of the Handicapped." At the Pick-Congress Hotel, 520 South Michigan Ave, Chicago. Info: Phone 617/969-0100, ext 4373).

JUNE 19-20, 1981 (Illinois): *Symposium—The Medical Consequences of Nuclear Weapons and Nuclear War,* Pick-Congress Hotel, Chicago. Sponsor: Northwestern University School of Medicine. Credit: 12, Category 1, CME. Info: Mary Lord, Physicians for Social Responsibility, PO Box 144, Watertown, MA 02172 (ph 617/924-3468). g5/81

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL ADMINISTRATIVE MEDICINE PROGRAM

May 26-June 14, 1981/Six Annual InterSession, Madison, Wisconsin

Decision Analysis for Clinicians—Friday, May 29, 7-8 pm; Saturday, May 30, June 6 and 13, 8 am-1 pm; and Sunday, May 31, June 7 and 14, 9 am-12 noon. *Dennis Fryback, PhD,* Instructor. Major topics are: decision trees, probability assessment, probability revision, utility assessment, sensitivity analysis.

Communication of Health/Policy Information by Clinician Executives—Friday, May 29 and June 5, 7-9 pm; Saturday, May 30 and June 6, 9 am-12 noon, and 1-4 pm. *Jeffrey Kunz, MD,* Instructor. Methods for establishing good relations with the news media, especially techniques for distributing and controlling publication of technical, controversial, clinician-executive's organization.

Clinical Administration in Health Care System—May 26, 27, June 1, 2, 3, 8, 9, and 10, 8 am-12 noon, and 1-3 pm. *Joy Calkin, PhD,* Instructor. Analysis of health care systems in light of organizational and small group constructs applied to problems encountered by clinicians in leadership positions.

Quality of Care: Evaluation and Assurance—Friday, May 29, June 5 and 12, 6:30-9:30 pm; Saturday, May 30, June 6 and 13, 8:30 am-12 noon, 1:30-3:30 pm, and Sunday, May 31, June 7 and 14, 8:30 am-12 noon. *Jay Norden, MD, MPH,* Instructor. The course addresses the current and future role of Professional Standards Review Organizations (PSRO's).

June 15-August 7, 1981: Summer Session Offerings

Legal Issues in Health Care Administration—June 15, 17, 22, 24, 29, July 1, 6 and 8; 7-9 pm. *Burton Wagner, JD,* Instructor. Analysis of the legal system and its influence on the provision of health care.

Values in Medical Care and Education—July 13, 15, 17, 20, 22, 24, 27 and 29; 7-9 pm. *Don Detmer, MD,* Instructor. Examination of the values of the present healthcare system and society at large, the ideological roots of the American political and educational philosophy, and the Waltenschauung of contemporary health professionals.

The offerings are available either for credit, audit, and/or CME Category I credit for those with a health professional degree. Info: **Administrative Medicine Program, University of Wisconsin-Madison, 1225 Observatory Dr, Madison, Wis 53706. Phone: 608/263-4889.**

JULY 18, 1981 (Illinois): AMA one-day intensive course on improving English pronunciation for foreign physicians. Formal credit in CME. Info: Henry Mason, Division of Professional Relations, AMA, 535 N Dearborn St, Chicago, IL 60610. Registration fees: $130 AMA members; $170 nonmembers; and $80 residents.

JULY 21-22, 1981 (Illinois): *Ninth Annual Breastfeeding Seminar for Physicians,* Conrad Hilton Hotel, Chicago. Approved 14 credit hours in Category I of AMA-PRA. Info: Carol Kolar, RN, Continuing Medical Education, La Leche League International, Inc, 9616 Minneapolis Ave, Franklin Park, Ill 60131, phone 312/455-7730. p5-6/81

AUGUST 20-23, 1981 (Illinois): Sixth annual convention, American College of International Physicians, Inc, Holiday Inn, Lake Shore Drive, Chicago.

AUGUST 29-SEPTEMBER 12, 1981 (Illinois): Illinois State medical Society announces new travel program, an *Alaskan Cruise,* aboard Sitmar Cruises' elegant TSS FAIRSEA, sailing from San Francisco. Arrangements made for a CME seminar. Flights from Madison and Milwaukee to San Francisco at cost of $175. Info: Illinois State Medical Society, 55 East Monroe St, Suite 3510, Chicago, Ill 60603 (ph 312/782-1654). g5-7/81

SEPTEMBER 25-27, 1981 (Indiana): *Second National Seminar on Community Cancer Care,* Hyatt Regency, Indianapolis. Sponsored by the Clinical Oncology Center and the Graduate Medical Center at the Methodist Hospital of Indiana, Inc. Info: Office of Continuing Medical Education, Methodist Hospital of Indiana, Inc, 1604 N Capitol Ave, Indianapolis, Ind 46204 (ph 317/924-8288). g5-8/81

OCTOBER 1-3, 1981 (Nebraska): Nebraska Medical Association Fall Session, Lincoln Hilton Hotel, Lincoln.

1981 AMA Seminar

Improving English Pronunciation for Foreign Medical Graduates

AMA Headquarters—535 N Dearborn St Chicago, Illinois (9:00 am-4:30 pm) Saturday, July 18, 1981

Course is designed to assist foreign physicians now in practice in the United States in improving spoken communications with their patients. Physicians attending will receive formal credits in continuing medical education.

Course will be taught by Mrs Elizabeth Lang, professor of English as a second language, Cuyahoga Community College, Cleveland, Ohio. Mrs Lang has developed a study manual and cassette tapes for home study.

There will be lectures and practice on producing the sounds of general American English, intensive oral drill and criticism of individual students, and practice in sustained discourse through reading and extemporaneous speaking.

Course is limited to 20 students. If it is oversubscribed by as many as 10, an additional course will be held on Sunday, July 19.

Registration fees: $130 for AMA members; $170 for nonmembers; and $80 for residents. (Includes nine practice tapes and 134-page manual.)

Further information on the course is available from Henry Mason, Division of Professional Relations, AMA, 535 N Dearborn St, Chicago, IL 60610. Course director is Mortimer Enright, head of the AMA's Speakers and Leadership Programs Section.

OTHERS

JULY 14-16, 1981 (Philippines): Medical Continuing Education on Internal Medicine and Cardiology, Manila Hotel, Manila, The Philippines. Info: Center for Continuing Education Programs (approved for Category I credit), c/o Hermosa Travel, Inc, 2526 N Lincoln Ave, Chicago, Ill 60614; tel 312/472-1280 (out-of-state call collect). (The same program will be presented again in Manila on Jan 2-4, 1982.)

JULY 29-AUG 8, 1981 (Caribbean): Ten-day cruise, departs Ft Lauderdale on July 29 and stops at St Maarten, Antigua, Barbados, Martinique, and St Thomas. Approved 23 credit hours of Category I of AMA-PRA. Info: International Conferences, Suite C, 189 Lodge Ave, Huntington Station, NY 11746. Phone: 516/549-0869. (See ad elsewhere in this section.)

AUG 22-SEPT 5, 1981 (Mediterranean): Fourteen-day cruise, departs Venice, Italy, and visiting Egypt, Israel, Turkey, and Yugoslavia. Approved 23 credit hours of Category I of AMA-PRA. Info: International Conferences, Suite C, 189 Lodge Ave, Huntington Station, NY 11746. Phone: 516/549-0869. (See ad elsewhere in this section.)

OCTOBER 17-21, 1981 (Louisiana): Annual Meeting, American Society of Anesthesiologists, New Orleans. Info: ASA, 515 Busse Highway, Park Ridge, Illinois 60068 (ph 312/825-5586).

AMA

JUNE 7-11, 1981: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 6-9, 1981: Interim AMA House of Delegates, Las Vegas, Nev.

FEBRUARY 25-28, 1982: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill. ■

Ninth Annual Illinois Congress on Continuing Medical Education

September 11-12, 1981

Friday, Sept 11, 7:45 pm to Saturday, Sept 12, 5:00 pm

Oak Brook Hyatt Hotel, Spring & Harger Roads

Oak Brook, Illinois

How Physicians Learn: Effective Methods in CME

This year's Congress, sponsored by the Illinois Council on Continuing Medical Education is the second of a four-year program cycle presenting all the fundamentals of CME planning. The 1981 program focuses on effective learning methods as well as skill in selecting methods likely to achieve specific CME Program Goals and Learning Objectives.

Highlighting this year's program will be *Howard S Barrows, MD,* Associate Dean/Education Affairs, Southern Illinois University School of Medicine, known internationally for his work in *problem-solving* and *simulations* in medical education.

Most of the Congress consists of small-group workshops, such as: Matching Methods to Needs, Teaching with Technology, Self-Directed Learning Techniques, Do's and Don'ts of Didactics, Medical Audit as a Learning Method. There also will be a special workshop for non-physician CME Coordinators.

For additional information, write or call the **Illinois Council/CME, 55 E Monroe, Suite 3510, Chicago, Illinois 60603 (ph 312/236-6110).**

AMA SYMPOSIUM

Diet and Exercise: Synergism in Health Maintenance

NOVEMBER 3-4, 1981
Lake Buena Vista, Florida
(Walt Disney World Complex)

Symposium will focus on the role of nutrition *and* exercise in the promotion of health and the treatment of major health problems. Emphasis will be on the physiologic effects of moderate habitual activity coupled with sound nutrition practices; *ie,* the role of nutrition and exercise in health maintenance and in the treatment of some of our chronic degenerative disease states.

Sponsored by the Department of Foods and Nutrition, American Medical Association, in conjunction with the AMA's Council on Scientific Affairs and Council on Continuing Physician Education, and the Florida Medical Association.

For further information contact: Department of Foods and Nutrition, AMA, 535 N Dearborn St, Chicago, IL 60610.

"WATS" LINE FOR MEMBERS

As a new service for its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is

1-800-362-9080

AVAILABLE PHYSICIANS LISTED IN NEW VERSION OF AMA REGISTRY

For communities and institutions looking for the services of a physician, or for physicians looking for a new practice location, the February 1981 editions of the *Opportunity Placement Register* and the *Physician Placement Register* are available.

The American Medical Association's opportunity register lists openings for physicians, indexed by specialty, type of practice, location and size of community, date of availability and financial arrangements. The physician register contains the resumes of physicians wishing to relocate.

Copies of the books and further information on the AMA programs are available from the Physicians' Placement Service, American Medical Association, 535 N Dearborn St, Chicago, Ill 60610.

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

1981 WHCLIP RATES TO DROP BY 47%. Due in large part to State Medical Society input, the Wisconsin Health Care Liability Insurance Plan (WHCLIP) will be granting substantial reductions in physician rates. Effective July 1, 1981, WHCLIP rates will be decreased by 47%. In addition, current (1980) rates have been reassessed and WHCLIP will be returning to insureds 30% of the premiums paid in 1980.

Despite the favorable experience of WHCLIP, however, the Patients Compensation Fund is again forced to increase physician fee assessments. While original recommendations called for a 32% increase, SMS Medical Liability Committee members Paul A Jacobs, MD, Milwaukee; and Russell A Quirk, MD, Racine, supported by data provided by the SMS-retained actuaries Victor O Schinnerer & Company, successfully challenged this proposal and won committee support for a 15% (rather than 32%) increase in physician fee assessments. The 15% increase was ultimately approved by the Board.

The following chart indicates the financial impact these changes will have on individual physicians.

	WHCLIP RATES			FUND FEES		TOTAL PAYMENT (WHCLIP + Fund)	
Class	*1980*	*1981*	*Amount of Refund of 1980 Rate*	*1980*	*1981*	*1980*	*1981*
1	$ 826	$ 438	$ 247	$ 194	$ 223	$1020	$ 661
2	1487	789	446	350	403	1837	1192
3	2549	1351	764	600	690	3149	2041
4	3388	1796	1016	798	918	4186	2714
5	4248	2252	1274	1000	1150	5248	3402
6	5097	2702	1529	1200	1380	6297	4082
7	6796	3602	2038	1600	1840	8396	5442
8	414	220	124	98	113	512	333

ETHICS POLICIES FOR PHYSICIANS IN NEW AMA PUBLICATION. Quality of life, allocation of health resources, illegal or excessive fees, confidentiality and informed consent are just some of the issues deliberated by the American Medical Association's Judicial Council in its new publication, *Current Opinions of the Judicial Council of the American Medical Association, 1981.* Included in the new guide are the revised Principles of Medical Ethics adopted by the AMA House of Delegates in 1980. *Current Opinions* supercedes all earlier publications of the Judicial Council. The booklet may be purchased from: Order Department OP-122, American Medical Association, PO Box 821, Monroe, WI 53566. Single copies are $4.

PHYSICIANS MORE EFFICIENT IN PATIENT SCHEDULING, STUDY SHOWS. Patients wait less time to see a physician in his/her office than in a hospital outpatient department or emergency room, according to a study conducted in 1977 and 1978 by the US Public Health Service. On the average patients waited 29.4 minutes in a physician's office, 45.3 minutes in a hospital outpatient department, and 38.2 minutes in a hospital emergency room. In general, dissatisfaction with the time patients waited to see a physician was relatively low, less than a sixth overall. Where waiting times were longer than 30 minutes, however, levels of dissatisfaction were much higher, ranging from 40.2 percent for waits from 31 minutes to an hour to as much as 67.9 percent for waits in excess of one hour. The study showed that the waiting time for an appointment for all types of services was longer in a hospital outpatient department (10.1 days) than in physician offices (6.9 days).

FORMS NOW AVAILABLE ON DENYING ACCESS TO PATIENT HEALTHCARE RECORDS. In 1980 the Wisconsin Legislature passed a new law concerning confidentiality of patient healthcare records. The new statutes (Sections 146.81-146.83) allow state and federal government agencies and researchers to have access to "private" patient healthcare records without the patient's informed consent under certain circumstances. Also included in the law, however, is a provision allowing a private pay patient to deny access by annually submitting to the healthcare provider a signed request on forms provided by the Department of Health and Social Services (DHSS). DHSS has announced that these forms, "Denial of Government Access to Health Care Records" (HSS-0002), and "Denial of Researcher Access to Health Care Records" (HSS-0003), are now available for ordering by physicians and other healthcare providers. The cost is $5.00 for a package of 25 forms and $12.50 for a package of 125 forms. When ordering please include your phone number. Questions concerning orders can be directed to Document Sales Office at 608/266-3358. ■

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JUNE 1981

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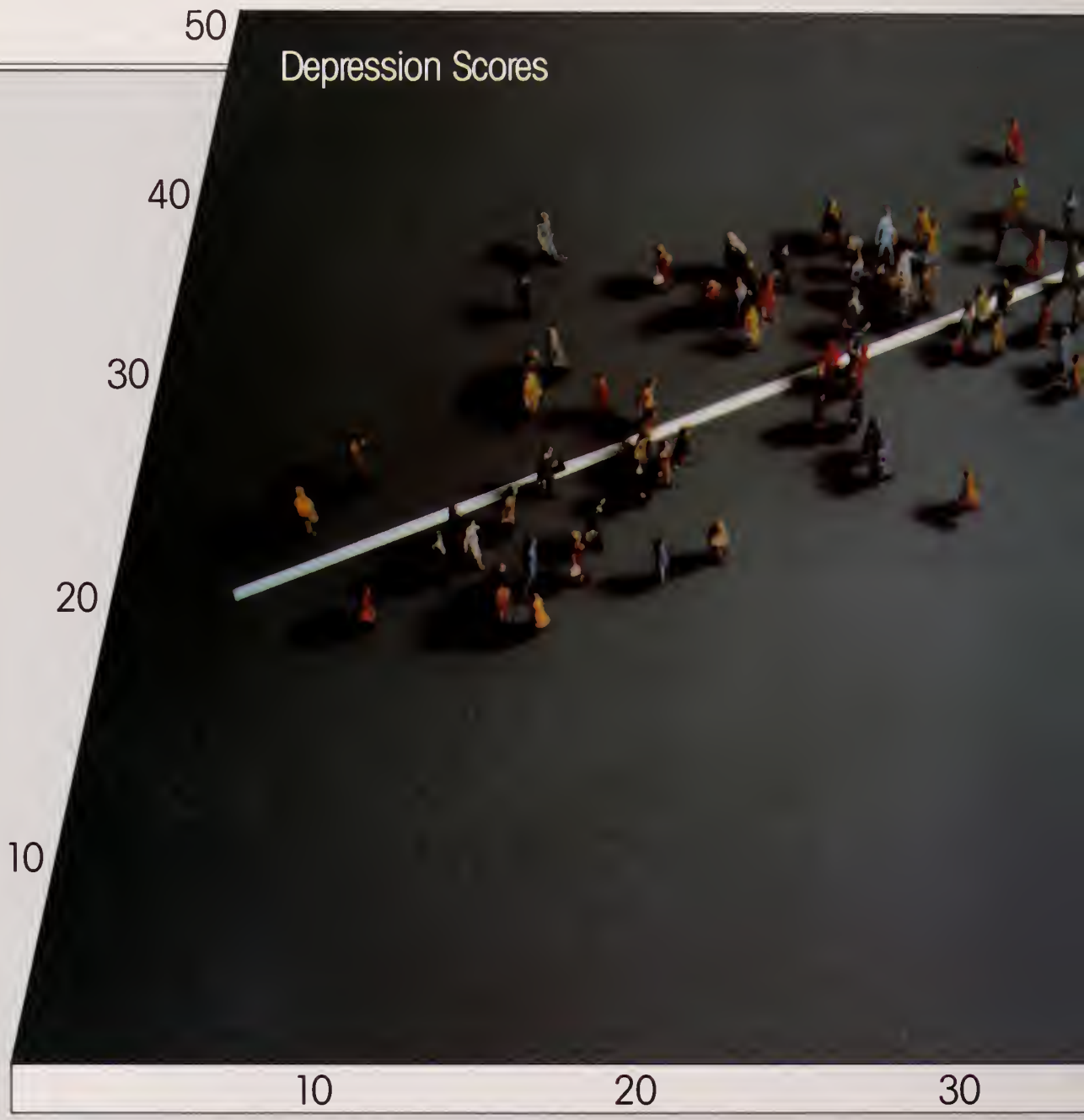

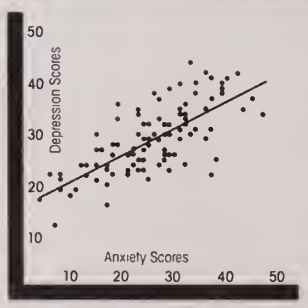

Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3]Adapted from Cloghorn, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

ROCHE

DEPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]

Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35*:1359-1365, 1978. **3.** Claghorn J: The anxiety-depression syndrome. *Psychosomatics 11*:438-441, 1970. **4.** The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137*:1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61*:217-225, 1979.

Anxiety Scores

50

In moderate depression and anxiety

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Relief without a phenothiazine

Please see summary of product information on next page.

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Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses Myocardial infarction and stroke reported with use of this class of drugs) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e g , operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives Concomitant use with other psychotropic drugs has not been evaluated· sedative effects may be additive Discontinue several days before surgery Limit concomitant administration of ECT to essential treatment See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period Not recommended in children under 12
In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects
Adverse Reactions: Most frequently reported are those associated with either component alone drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Antichalinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.
Other Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling
Overdosage: Immediately hospitalize patient suspected of having taken an overdose Treatment is symptomatic and supportive. I.V administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime Single *h.s* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required Limbitrol 5-12 5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses
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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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The *Wisconsin Medical Journal* gratefully acknowledges publication support of this "Blue Book" issue through a contribution from the **Crownhart Memorial Account** of the State Medical Society's Charitable, Educational and Scientific Foundation.

Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Inflated savings

LAST YEAR A STATE formula indicated that 49 additional nursing home beds were needed for Rock County. Two units in the county, both having existing nursing home beds, expressed interest in expansion.

One of these, the Edgerton Hospital, filed a "statement of intent" for 24 nursing home beds to be in conjunction with an existing hospital at a cost of $250,000. The HPC (Health Planning Council [District 1 Health Systems Agency]) not only rejected the request but claimed a saving of $3.2 million! This was one of several similar hospital cost "savings" reported by the HPC in a news release. How these inflated savings were determined was not explained.

Similarly the HPC claimed savings by rejecting a hospital program at Portage in Columbia County —after the construction was already well under way.

The HPC is one of seven district health systems agencies (HSAs) in the state. These HSAs consist of a number of dedicated volunteers who serve without pay plus a paid staff. For example in one district of 11 counties with 25 hospitals there are 18 or 19 full-time paid staff persons. As one hospital administrator said at a public meeting: "They (HSA staff persons) are fighting for their lives and I think they are trying to come up with figures that show they are doing the public some good." This is the repetitious story of a bureaucracy trying to justify its continued existence.—VSF

AMA addendum

A "LEGISLATIVE ALERT" relative to the repeal of the national health planning law has just been sent out by the AMA. The AMA has opposed that law since its enactment. Now two Representatives are cosponsoring a bill (HR 3666) for its repeal.

The "Alert" points out that repeal of the Act is absolutely necessary to end federal interference in local planning decisions. The Reagan administration has announced its intent to phase out funding for the program over a three-year period. However, there would still be the federal requirement that states enact certificate-of-need laws. This, of course, will intensify the lobbying of health planners to save the program and initiate the circulation of scare stories about potential increases in hospital construction.

The AMA's position has been taken for a number of reasons.

1. The federal government has imposed federal regulations upon what should be primarily locally-directed health planning.
2. In exercising its control, the federal government has targeted short-term cost-containment objectives rather than planning for local health needs.
3. The planning program is not cost-effective.
4. The program is anti-competitive, creating barriers to market entry through burdensome certificate-of-need and other approval requirements.
5. The law and regulations are highly complex, resulting in excessive amount of time and resources being devoted to red tape instead of delivery of care.

It is therefore essential to initiate broad support for HR 3666. Write your Congressman, asking him to cosponsor the repeal of the federal health planning law or to contact members of the House Energy and Commerce Committee urging their support.

—VSF

Instructions to delegates

FREQUENTLY IN THE past year meeting with County Medical Societies, the question was raised, "Do our delegates to SMS have to vote as we instruct them at our caucus?" At the House of Delegates Annual Meeting in March, when the vote concerning unified membership was taken, this question was again raised. Fortunately, Dr Raymond Zastrow, an expert parliamentarian, was there to quote from Sturgis. I felt his statement was an interesting observation that might serve a useful purpose and, therefore, deserved wider distribution.

County Societies have the option to instruct or partially instruct, or leave them uninstructed, but Doctor Zastrow reading from Sturgis stated: "Except in unusual circumstances it is not wise to give delegates explicit instructions as to how they must vote. If the delegate is simply a messenger carrying a vote, it is more economical to send a telegram." It would seem that Ms Sturgis has a sense of humor.

This is not to negate the importance of the County Societies discussing controversial issues and letting their delegates know their feelings. It would be anticipated that in most instances the delegate would

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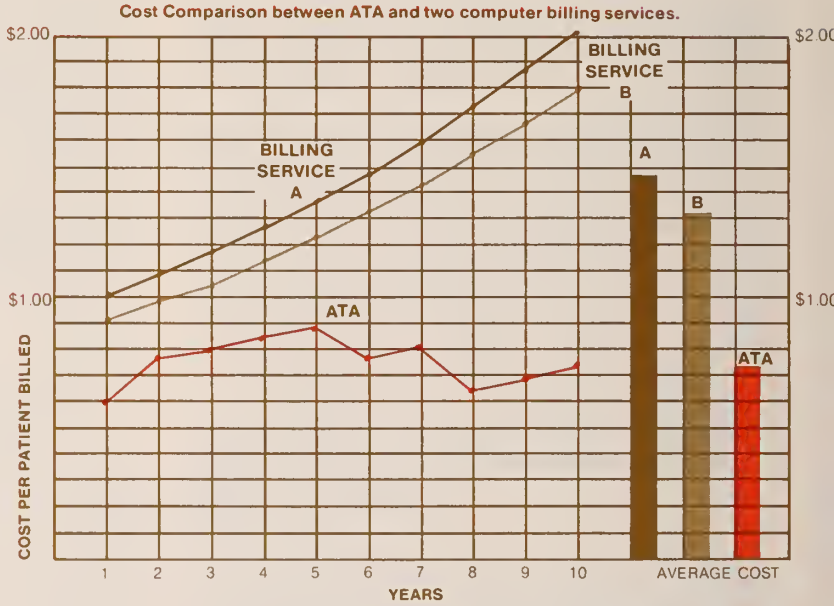

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follow the instructions from the local society if he or she expected to be reelected, but it is thought at times, in the process of debate, issues are raised that have not been considered at the county level, and these may have a major impact in the delegates' final decision on the vote. This, of course, is the reason for the recommendation that there be some leeway, according to delegates, so that they may cast an informed ballot.—RFL

Not like they used to

LAST YEAR WHILE touring in Belgium I had the opportunity to visit a hospital that was built in the year 1250 AD. The hospital was in continuous use until 1975.

It was not possible to ascertain why the facility was closed. One wonders if it did not "come up to code" or if some ambitious hospital administrator decided he needed a "new plant." In the United States when a hospital is 30 to 40 years old, it is considered obsolete and unsafe. Apparently they just don't build them like they used to.—VSF

Irresponsible and unwarranted

AT ITS APRIL meeting the University of Wisconsin Board of Regents was told that the State Joint Finance Committee was recommending that the size of each medical class be reduced from 159 to 139.

Dr Ben Lawton, Regent from Marshfield, stated that "The decision out of the blue to reduce class size is extremely disruptive and based on no information gathered by the State. It would appear the fiscal decision was made and a rationale developed to fit it." He added further that he hoped clearer heads would prevail.

Regent Arthur DeBardeleben observed that there had been a suggestion that the State Medical Society was behind the proposed cut in class size. Doctor Lawton said he didn't know anything about that and, of course, neither did anybody from the State Medical Society or anyone else.

On the contrary, the State Medical Society officers have recommended to the Regents and to the Joint Finance Committee that the size of the medical school classes not be changed.*

Providentially, Mr DeBardeleben's term as a Regent is about to end. If this irresponsible and unwarranted slur on the State Medical Society is characteristic of his function as a Regent, his departure from the Board cannot come too soon.—VSF

*The Joint Finance Committee subsequently recommended that the size of the classes not be cut.

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ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
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High, hot and—

YEARS AGO WITTY young hospital interns described enemas as "high, hot, and a hell of a lot." Recently I referred to high colonic irrigations in a facetious vein. Now this watery procedure has been found to have a more serious aspect. A clutch of chiropractors has been enjoined to cease and desist the utilization of this ancient and worthless practice as they had touched off a minor epidemic of amoebic dysentery. This was spread by the use of contaminated equipment in this untidy irrigation. Anyway, what does this have to do with vertebral subluxation?

And just as disjointed is the practice of dispensing megavitamins by chiropractic nutrition centers. Even the Wisconsin Chiropractic Examining Board had taken notice of this and ordered a Waupaca chiropractor to separate his chiropractic offices from his "Nutrition Center." Again, what's the spinal connection?

The connection, apparently, involves the "mixers" who believe in broadening their profession. The "straights" believe chiropractors should stick to their traditional role of adjusting misaligned vertebrae. Last December an unfortunate young man who had previously been a house painter and sportscaster was expelled from a chiropractic college the day before he was to graduate. He was responsible for a cartoon published in an underground newspaper called "The Spinal Connection." The cartoon suggested a sex act between a couple intended to represent two chiropractic organizations. The school and student leaders didn't share his sense of humor. The complaint about the cartoon was not the sex act but that it was intended to "disparage two big, revered organizations in the chiropractic profession."

In any event, and regardless of one's sense of humor, it behooves the Wisconsin Medical Examining Board as well as the Chiropractic Examining Board to maintain strict surveillance so that the mix does not become widespread.—VSF

Bastardized barbarisms

BARBARISMS ARE distortions of words in good use. There has been a great trend to convert nouns into verbs by the addition of a final "ize."

For some years the terms maximize and minimize have been quite popular. Recently I encountered bureaucratize and conceptualize. However, the ultimate came up in a conversation with a resident physician who allowed that he didn't think the orthopods would "surgerize" the patient.

And with that I will finalize.—VSF ■

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Retention and inspection of patients' records

IT IS GENERALLY agreed that ownership of medical and hospital records rests, respectively, with the physician and the hospital. Their beneficial ownership, that is the right to have them used for one's benefit, is in the patient although the right to possession remains in the physician or hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because of the long-standing uncertainty regarding the rights of physicians, hospital personnel, patients and others in regard to health care records, efforts both statutory and private have been made to clarify this situation. In 1959 the State Medical Society of Wisconsin and the Wisconsin Hospital Association jointly developed an *Interpretation* seeking to define what is a health record and restate the respective rights of various interested parties in them. This *Interpretation* was printed in the June 1975 Blue Book issue of the *Wisconsin Medical Journal.* (74 *WNJ* 30)

The law under which the *Interpretation* was prepared has been subsequently amended. To the extent of that amendment, the *Interpretation* is no longer valid. It does provide a framework from which to view the issues involved, this framework having been developed jointly by the health professionals most directly involved. The new statute, Sec. 804.10(4), Wis. Stats., is discussed in the box accompanying this article. It deals with authorization by a patient for the examination or inspection of that patient's health care records.

More recently, Secs. 146.81-.83, Wis. Stats., were enacted effective 1980. This new law deals with the release of health care records by consent and without consent. Health care records are defined as "all records related to the health of a patient prepared by or under the supervision of a health care provider." Consent may be given by the patient or one legally permitted to act on the patient's behalf. Consent must contain the name of the patient, the purpose of disclosure of the records, the type of information to be disclosed, the person to whom disclosure may be made, which providers are to make the disclosure, and the time period during which the consent is effective. Access without consent of the patient is permitted for staff, accreditation or review committee use, performance of health care services or consultation regarding them, billing, collecting and payment of claims, on court order, on written request from an appropriate government agency, and for research purposes subject to particular conditions. The new law also covers the subject of patient access to health care records.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

A. Retention of Records

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 18 who are mentally competent; (2) over 18 who are mentally ill; and (3) under 18.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not legal considerations.
2. A mentally normal patient of legal age has *3* years within which to sue *for personal injuries.* If a patient elects to sue on *a contract* rather than for alleged *negligence,* he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such

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unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. There is no *legal* requirement for accommodating a former patient longer than the suggested 6 years, although where fraud is alleged, the injured party has 6 years in which to sue *after* discovery of the fraud. For example, a surgeon is chargeable with "fraud" who is aware he has left a foreign object in a patient's body but does not disclose that fact to the patient, or the latter's representative.

3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 18 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 18 and mentally ill at the time of his treatment or hospitalization, or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within one year of his recovery, and if he does not recover, within a maximum of 8 years after the alleged negligence.
   C. If the patient is a mentally normal minor at the time of treatment or hospitalization, suit for injuries resulting from alleged malpractice by a health care provider must be brought on behalf of the minor within the later of: (i) 3 years after the injury or (ii) one year from the date the injury was, or should have been, discovered within a maximum of five years after the alleged injury, or (iii) the time the minor reaches the age of 10.
   D. If the patient was a minor and mentally ill at the time of the alleged negligence, and becomes mentally normal by age 18, he must sue for the alleged negligence by the time he is 20, or within three years from the date of the injury, whichever is later. If such patient remains insane after reaching age 18, his guardian must start suit within two years of his recovery, or before the patient is 20, whichever occurs later, all within a maximum of eight years after the alleged negligence.

4. To the extent that patients' records are retained to assist in collection of accounts, such claim must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

B. Inspection and Copying of Medical Records:

As a general rule, the right to inspect or copy medical records is based on the consent for such action by the patient or one legally authorized to act for the patient. The issue may arise in any of several situations and in the absence of a statutory exception covering the particular situation the physician should permit inspection and copying of a patient's medical records only by the patient or by one who has a written authorization from the patient (or one legally allowed to act on behalf of the patient) stating the extent of the authorization and describing the records covered by the authorization.

SECTION 804.10(4)

The general rule regarding inspection and copying of medical records is codified in Section 804.10(4), Wisconsin Statutes. It is set out in the box below.

A physician or hospital administrator, and anyone designated by either of them is urged to read this article *before* allowing the inspection or copying of medical records and reports which are in his custody.

STATUTE: 804.10(4)

"804.10(4). Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of the death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

An authorization from or on behalf of a patient allowing the designated person to inspect and copy medical or hospital records or reports concerning the patient's care and treatment may not specify what specific records are covered. The physician on the other hand may have records that go back many years and cover more than one treatment or series of treatments, and more than one illness or hospitalization, or more than one member of a family.

Before complying with the request of a patient to inspect and copy his records, the physician should confer, if practical, with the patient or his representative to ascertain *what* illness, *what* treatment, and *what* period of time are intended by the authorization. If by any chance the records or reports contain material relating to conditions which would be embarrassing to the patient or which might involve other members of the immediate family, the patient or a representative might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any such parties.

Some physicians are requesting not only that the time periods to be copied from a medical record or report be specified, but also that each particular illness be specified in the authorization from the patient.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member.

Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Following are some major considerations and safeguards to be observed by a custodian of medical records and reports:

1. Validity of Authorization

Upon being presented with an authorization form for the inspection or copying of medical records and reports, physicians or hospitals must assure themselves that (1) the patient in fact signed the authorization, (2) was of legal age, and (3) had the *mental capacity* to know what he was signing. A minor or incompetent must act through his guardian. Where there is no formal guardianship of a minor, a parent may sign as the natural guardian except where the minor is emancipated as by marriage or self-support.

The physician or hospital must take such precautions as are necessary to satisfy themselves that those designated in the authorization are thereby empowered to inspect and copy the medical records or reports covered by the authorization.

The physician or hospital representatives must also be satisfied that the *person presenting* the authorization to inspect or copy records is the *identical person named* in such instrument. So long as there is any reasonable doubt as to the identity of a person presenting authorization to inspect or copy records, the physician (or his representative) or the hospital (or his representative), depending upon which place the authorization is presented, is warranted in refusing to honor such authorization. The same is true if there is any substantial question as to the authenticity of the signature or the mental capacity or age of the patient.

The statute authorizes the personal representative, or the beneficiary of a life insurance policy, to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Domiciliary Letters" or other documentary evidence of appointment or authorization which are issued by the Circuit Court branch handling probate matters.

In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) the person signing the authorization is the beneficiary under the policy.

The burden of proof is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized. On being satisfied that the authorization presented is properly signed, as previously outlined, that the person presenting it is the person named therein, and that no question of mental capacity or of minority is involved, it then becomes the duty of the physician or hospital to permit such person to inspect and copy "any medical or hospital records or reports concerning" the care or treatment designated in the authorization. Exactly *what* records and reports may be inspected and copied is discussed in point 2 immediately following.

2. What Can Be Inspected And Copied

It is first necessary to determine what must be made available for inspection and/or copying.

It is believed that under a fair interpretation of subsection (4) the physician's records and reports (office or hospital), and the hospital clinical record or chart should be made available for inspection or copying.

In the case of x-rays there seems to be some disagreement among legal authorities as to whether they are part of the medical record as such, or are technically photographs. It is advised that x-rays be

inspected *only* under proper supervision, in the case of a physician's office by the physician in charge, an associate, or the designee of either, in the case of a hospital or other institution by a qualified physician, or in the event of his unavailability, by a person designated by the administrator.

X-rays must *not* be taken from the office of a physician or other custodian by a patient unless required by a court order or subpoena. When either of the latter is served on the custodian of medical records or reports, Section 804.10(4) *is no longer applicable,* and the authorization is no longer in force.

One of the results of the increasingly comprehensive services of the modern hospital, especially teaching institutions, is the development and maintenance of *two* types of records relating to a patient. One relates directly to his care and treatment, and is the direct professional responsibility of the attending physician and of those acting under him, and may be described as the "official records and reports." The other has sometimes been described as "educational records," which are typically made by nonmedical personnel as part of their training, or at least for purposes not directly related to the "medical care and treatment" of the particular patient.

It is believed that no record or report, other than that made or approved by the physician in charge, or by a consultant, or resident, or by a registered nurse who is recording her/his acts or observations made pursuant to special or standing orders, technically relates to the "medical care or treatment" of the patient, as that phrase is used in the new statute. Nothing but one of the above should be furnished for inspection or copy.

Any *other* writings should be kept *separately* but *not* as a part of the patient's official record, for the reason that the persons making such writings are not professionally responsible for the patient, are not licensed to practice medicine, and are not necessarily recording acts or observations made pursuant to orders of the attending physician. Such writings are not authentic "records" relating to the care of treatment of the patient.

3. Safeguards

The following safeguards are recommended:

(a) Section 804.10(4) does *not* in words or by implication, give a right *to remove* any records from a physician's office, or hospital, the records being the legal property of the physician or hospital.

As an act of prudence, the hospital or physician should require that inspection and copying be carried on *in the presence* of a custodian (hospital or physician), or the representative of either. This statute does *not* require a physician or hospital to copy any records at the request of a patient or his representative. (See below, "Patient Access" under Section 146.83.) If a request is made by a patient or his representative, and the request is granted, the physician or hospital making such copy is entitled to make a reasonable and realistic charge for doing so.

As a precautionary measure to hospital administrative personnel and to physicians, it is suggested that under no circumstances should copies of any medical or hospital records or reports, which are prepared by a representative of the patient, be signed, initialed or subscribed to in any manner that may indicate authenticity and accuracy of such copies.

(b) Few people, other than medically trained personnel, know what is important in a hospital or medical record. For that reason a hospital librarian or other authorized person, or a physician, may in some situations be able to satisfy a request by making inquiry as to what the patient or his representative really wants from the records, and reading the material relative to the inquiry. This may save a great deal of examining, copying, and inconvenience to everyone concerned.

(c) The word "forthwith" used in connection with the right to inspect and copy records does *not* mean "immediately," but as soon as the convenience of a physician, an administrator, or a record librarian, *reasonably* permits, after taking into account the urgency of prior demands on their time and personnel and whether advance notice had been given of the demand of the particular patient.

(d) When there is any indication that legal proceedings may ensue, the physician or hospital served with a proper authorization to examine or copy a patient's records should promptly notify the insurance carrier of this fact, and also the attorney of the physician or hospital. It is recommended that, in the interest of the patient, the hospital, and the physician, the knowledge of any such authorization be given by the person receiving same to the other interested parties.

4. No Authorization Forms Suggested

Since no words appear in Section 804.10(4) prescribing the form of an authorization to inspect and copy a patient's medical or hospital records or reports concerning his care or treatment, model forms are not suggested. (See below the elements of "informed consent.") The observance of the precautions and safeguards emphasized earlier in this article should assure that the patient's interest is protected while at the same time protecting the professional or institutional provider of services.

SECTIONS 146.81-.83

The most important exceptions to the general rule of confidentiality have been collected in Sections 146.81-.83, Wis. Stats. This law, adopted in 1979, defines the essential terms relating to "patient health care records," codifies the right of patients to have access to their records, recognizes the general rule of confidentiality of records, and enumerates the major exceptions to the general rule. A copy of Sections 146.81-.83 appears in boxes on following pages.

146.81 Definitions. In ss. 146.81 to 146.83:

(1) "Health care provider" means a nurse registered or licensed under ch. 441, a chiropractor licensed under ch. 446, a dentist licensed under ch. 447, a physician, podiatrist or physical therapist licensed under ch. 448, an optometrist licensed under ch. 449, a psychologist licensed under ch. 455, a partnership thereof, a corporation therof that provides health care services, an operational cooperative sickness care plan organized under ss. 185.981 to 185.985 that directly provides services through salaried employes in its own facility, or an inpatient health care facility as defined in s. 140.85(1).

(2) "Informed consent" means written consent to the disclosure of information from patient health care records to an individual, agency or organization containing the name of the patient whose record is being disclosed, the purpose of the disclosure, the type of information to be disclosed, the individual, agency or organization to which disclosure may be made, the types of health care providers making the disclosure, the signature of the patient or the person authorized by the patient, the date on which the consent is signed and the time period during which the consent is effective.

(3) "Patient" means a person who receives health care services from a health care provider.

(4) "Patient health care records" means all records related to the health of a patient prepared by or under the supervision of a health care provider, but not those records subject to s. 51.30.

(5) "Person authorized by the patient" means the parent, guardian or legal custodian of a minor patient, as defined in s. 48.02(9) and (11), the guardian of a patient adjudged incompetent, as defined in s. 880.01(3) and (4), the personal representative or spouse of a deceased patient or any person authorized in writing by the patient. If no spouse survives a deceased patient, "person authorized by the patient" also means an adult member of the deceased patient's immediate family, as defined in s. 632.78 (3) (d). A court may appoint a temporary guardian for a patient believed incompetent to consent to the release of records under this section as the person authorized by the patient to decide upon the release of records, if no guardian has been appointed for the patient.

146.82 Confidentiality of patient health care records.

(1) CONFIDENTIALITY. All patient health care records shall remain confidential. Patient health care records may be released only to the persons designated in this section or to other persons with the informed consent of the patient or of a person authorized by the patient.

(2) ACCESS WITHOUT INFORMED CONSENT. (a) Notwithstanding sub. (1), patient health care records shall be released upon request without informed consent in the following circumstances:

1. To health care facility staff committees, or accreditation or health care services review organizations for the purposes of conducting management audits, financial audits, program monitoring and evaluation, health care services reviews or accreditation.

2. To the extent that performance of their duties requires access to the records, to a health care provider or any person acting under the supervision of a health care provider or to a person licensed under s. 146.35 or 146.50, including but not limited to medical staff members, employes or persons serving in training programs or participating in volunteer programs and affiliated with the health care provider, if:

a. The person is rendering assistance to the patient;

b. The person is being consulted regarding the health of the patient; or

c. The life or health of the patient appears to be in danger and the information contained in the patient health care records may aid the person in rendering assistance.

3. To the extent that the records are needed for billing, collection or payment of claims.

4. Under a lawful order of a court of record.

5. In response to a written request by any federal or state governmental agency to perform a legally authorized function, including but not limited to management audits, financial audits, program monitoring and evaluation, facility licensure or certification or individual licensure or certification. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department. The provider, if a hospital or nursing home, shall submit a copy of the signed form to the patient's physician.

6. For purposes of research if the researcher is affiliated with the health care provider and provides written assurances to the custodian of the patient health care records that the information will be used only for the purposes for which it is provided to the researcher, the information will not be released to a person not connected with the study, and the final product of the research will not reveal information that may serve to identify the patient whose records are being released under this paragraph without the informed consent of the patient. The private pay patient may deny access granted under this subdivision by annually submitting to the health care provider a signed, written request on a form provided by the department.

(b) Unless authorized by a court of record, the recipient of any information under par. (a) shall keep the information confidential and may not disclose identifying information about the patient whose patient health care records are released.

continued on next page

continued from preceding page

146.83 Patient access to health care records.

(1) Except as provided in s. 51.30 or 146.82 (2), any patient or other person may, upon submitting a statement of informed consent:

(a) Inspect the health care records of a health care provider pertaining to that patient at any time during regular business hours, upon reasonable notice.

(b) Receive a copy of the patient's health care records upon payment of reasonable costs.

(c) Receive a copy of the health care provider's X-ray reports or have the X-rays referred to another health care provider of the patient's choice upon payment of reasonable costs.

(2) The health care provider shall provide each patient with a statement paraphrasing the provisions of this section either upon admission to an inpatient health care facility, as defined in s. 140.85 (1), or upon the first provision of services by the health care provider after April 30, 1980.

(3) The health care provider shall note the time and date of each request by a patient or person authorized by the patient to inspect the patient's health care records, the name of the inspecting person, the time and date of inspection and identify the records released for inspection.

1. Definitions

The statutory definitions of "health care provider," "Patient," and "patient health care records" are virtually all inclusive. Section 146.81, Wis. Stats. The law is intended to cover all health records of all patients of all providers.

In addition the law defines "informed consent." This is the statutory equivalent of the authorization referred to above. It means the *written* consent for disclosure of information from a patient's health care records and must include: the patient's name, the purpose for disclosure of the information, the type of information to be disclosed, to whom disclosure may be made, what providers must make the disclosure, the date of the consent, the period during which the disclosure consent is effective, and the signature of the patient or the "person authorized by the patient" (also a defined term).

As defined, "informed consent" is more specific and detailed than general authorization for inspection and copying records as discussed above. Because of the inclusive wording of the definitions it can be argued that all releases of information from health records are subject to this part of the law, notwithstanding the different phrasing of Section 804.10(4). For safety's sake it would be well to insist that any consent or authorization meet the standards of Section 146.81.

Other inconsistencies between the definitions in Sections 146.81 and 804.10(4) are relatively minor but may be significant in particular situations (e.g., disclosure of information from the records of a deceased patient).

2. Statutory Exceptions

The general rule of confidentiality of patient records is reiterated in Section 146.82. Following that statement the law lists six situations in which information from a patient's health care records may be released without informed consent. These include: management, financial, and service audits and accreditation; treatment or consultation regarding treatment of the patient; billing and collection of claims; under court order; government investigations; and research, where the product of this research will not identify individual patients. As to the last two (government investigation and research) private pay patients may deny access to their records by executing a form provided by the Department of Health and Human Services. (This form was not available for several months after the law became effective.) Anyone obtaining information under these exceptions may not, without court authority, disclose the information received.

Perhaps the most critical exception deals with governmental investigations. This includes the investigation of complaints by license law agencies. This exception exists if there is a written request by the agency and it is to assist it in performing a legally authorized function. The power to compel disclosure is conditioned upon the agency complying precisely with the law. If a physician receives such a request, care should be exercised to determine that it meets the requirements of the statute since this is an exception to the general rule of confidentiality.

Where the governmental investigation is being conducted to ascertain whether a physician has been guilty of unprofessional conduct, an administrative rule of the Medical Examining Board, Med 12.03(1), must be considered to determine whether the agency's powers are being lawfully exercised. This rule, which establishes the Examining Board's investigative procedures, permits such investigations to be conducted by an agent of the Examining Board acting under the supervision and direction of the secretary or another member of the Examining Board. There is some conflict in the law between the powers of the Examining Board and the Department of Regulation and Licensing in investigative matters but any investigation conducted under the authority of the Examining Board must meet its standards.

3. Patient Access

The law also addresses patient access to health records. Section 146.83, Wis. Stats. A patient or one with a patient's "informed consent" may inspect that patient's records at reasonable times, obtain copies of these records upon payment of reason-

able costs, and receive copies of X-ray reports or have the X-rays referred, also upon payment of reasonable costs.

Physicians providing first services to a patient after April 30, 1980, are to provide a statement paraphrasing patient access rights to the patient. Physicians are to keep a log of patient access requests by time and date, person authorized to inspect the records, time and date of inspection, and identity of records inspected. ■

Denial of Researcher Access to Health Care Records

(Private Pay Patients Only)

State of Wisconsin, Department of Health & Social Services, HSS-0003

Patient's Name
Patient's Birthdate
Health Care Provider

Completion of this form is entirely optional. You do not have to sign this form to receive care or services. Please read the following points before deciding whether you wish to sign.

1) In order to perform studies of health care, researchers affiliated with your health care provider may wish to review your health care records. These researchers have a legal duty to keep your identity confidential and to make sure that information from your health care records is not given to anyone who is not connected with the research.
2) State law says that a private pay patient may choose to keep researchers from reviewing his or her health care records; this may be done by signing the Denial of Researcher Access statement below. Please feel free to discuss this matter with family, friends or an attorney.
3) If you decide to sign this form, you will need to sign a new form each year that you wish to deny access to your records.
4) If you sign this form and later change your mind and decide to let researchers review your health care records, you may cancel the Denial of Researcher Access statement below at any time by signing a written cancellation statement and giving it to your health care provider.

DENIAL OF RESEARCHER ACCESS TO HEALTH CARE RECORDS
(Private Pay Patients Only)

I have read the above information and understand that I do not have to sign this form to receive health care services. I understand that by signing this form, I will keep researchers from reviewing my health care records for a period of one year from the day I sign it. I also understand that I may cancel this statement at any time by signing a written cancellation statement. (S. 146.82 (2) (a) 6., Stats.)

Signature of Patient
(or Legal Guardian) _____ Date _____

Denial of Government Access to Health Care Records

(Private Pay Patients Only)

State of Wisconsin, Department of Health & Social Services, HSS-0002

Patient's Name
Patient's Birthdate
Health Care Provider

Completion of this form is entirely optional. You do not have to sign this form to receive care or services. Please read the following points before deciding whether you wish to sign.

1) State and federal law directs government agencies to make sure that doctors, nurses, hospitals, nursing homes and other health care providers give health care of good quality in a safe setting and protect patient rights.
2) To make sure that health care services meet the basic legal requirements, state and federal agencies may need to review patient health care records. These records tell agencies how patients have been treated and can be very important during any investigation of alleged poor care, patient abuse, fraud, or patient rights violations. These agencies have a legal duty to keep the records they review confidential.
3) State law says that a private pay patient may choose to keep state and federal agencies from reviewing his or her health care records; this may be done by signing the Denial of Government Access statement below. Please feel free to discuss this matter with family, friends or an attorney.
4) If you decide to sign this form, you will need to sign a new form each year that you wish to deny access to your records.
5) If you sign this form and later change your mind and decide to let state and federal agencies review your health care records, you may cancel the Denial of Government Access statement below at any time by signing the Cancellation Statement on the back of your copy of this form or your own cancellation statement and giving it to your health care provider.

DENIAL OF GOVERNMENT ACCESS TO HEALTH CARE RECORDS
(Private Pay Patients Only)

I have read the above information and understand that I do not have to sign this form to receive health care services. I understand that by signing this form, I will keep state and federal agencies from reviewing my health care records for a period of one year from the day I sign it. I also understand that I may cancel this statement at any time by signing the statement on the back of this copy or my own cancellation statement. (S.146.82(2)(a)5., Stats.)

Signature of Patient
(or Legal Guardian) _____ Date _____

(Note: If you are in a hospital or nursing home, a copy of this form will be sent to your private physician once it is signed.)

"Denial of Access" forms available from DHSS

The new state law governing confidentiality of patient health care records (Sec. 146.81-146.83, Wis. Stats.) allows state and federal government agencies and researchers to have access to private patient health care records without the patient's informed consent under certain circumstances. Also included in the law, however, is a provision allowing a private pay patient to deny access by annually submitting to the health care provider a signed request on forms provided by the Department of Health and Social Services (DHSS).

DHSS recently announced that these forms, "Denial of Government Access to Health Care Records" (HSS-0002) and "Denial of Researcher Access to Health Care Records" (HSS-0003), are now available and can be ***purchased from the Document Sales Office, Department of Administration, PO Box 7840, Madison, Wisconsin 53707; or phone (608) 266-3358.*** (They are *not* available through the DHSS or the State Medical Society.)

The forms come in packages of 125 for $12.50 or 25 for $5. Sample copies of these forms appear on opposite page for informational purposes. Physicians should note that the original forms, which will be ordered, have copies for the health care provider as well as the patient. Both forms also include on the reverse side (not printed here), a means by which the patient can cancel his previous denial of access.

Patient's right of access to their medical records

The law requires all physicians and hospitals to advise their patients of that patient's right of access to their medical records. The notice, as reproduced below, should be posted in physicians' offices at a place easily seen by all patients. (Such notice [for posting] was sent to all SMS members last October.) Patients may receive information from their record upon completion of an "informed consent" release form (see copy at right.) ■

TO ALL PATIENTS

This notice is made to comply with a state law [sec. 146.81 to 146.83, Wis. Stats.] which requires that you be informed of your right of access to your health care records. This law also permits records to be released to others without your permission under certain conditions.

Under this law, after you have signed a statement of "informed consent," you may:

- Inspect your health care records during regular business hours upon reasonable notice;
- Receive a copy of your records upon payment of the cost of reproduction.
- Receive a copy of x-ray reports, or have x-rays referred to another health care provider, upon payment of the costs of reproduction.

This law also permits your health care records to be released without your consent to other persons or organizations who are required to keep the information confidential. Examples of this type of release are:

- To health care personnel working under the supervision of a physician if they are assisting in your care, consulted about your care, or for record keeping or billing purposes;
- Upon an order of the court;
- To medical review committees, hospital staff committees, etc. in order to review the quality of care being rendered;
- In the event of a legally authorized request by a governmental agency. If you are not a medicare, medicaid or other governmental assistant recipient, you may refuse to permit release to these governmental agencies by annually completing a form prepared by the Wisconsin Department of Health and Social Services.

"Informed consent" forms and the forms to prevent release of your private care records to governmental agencies are available through this office. (See reverse side for cnmplete text of law.)

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____ do hereby
(name of patient)

consent to and authorize _____,
(name of physician or health care institution)

to disclose to _____
(specific individual or organization)

information from my medical records relating to my identity, diagnosis, prognosis or treatment compiled during my medical treatment(s)/hospitalization from _____ (date) to _____ (date). I understand

that the specific type of information to be disclosed includes: _____

_____

I understand that this consent may be revoked except to the extent that action has already been taken in reliance thereon, and that this authorization for disclosure will be effective until:

_____
(time or condition)

_____
Signature of Patient . . . . . OR

_____
Person Authorized by the Patient* and

_____
his/her relationship to patient

_____
Witness

Dated this _____ day of _____, 19____.

NOTE TO RECIPIENT OF INFORMATION. This information has been disclosed to you from confidential records, which are protected by law. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.

*NOTE: Person authorized by the patient means the parent, guardian, or legal custodian of a minor patient or a patient adjudged incompetent; the spouse or personal representative of a deceased patient; or any person authorized in writing by the patient which is witnessed and dated.

MUST A
Wisconsin Physician Report?

1. Deaths?

The Wisconsin Statutes requires that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:

a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
b. All homicides.
c. All suicides.
d. All deaths following an abortion.
e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
f. All deaths following accidents, whether the injury is or is not the primary cause of death.
g. When there was no physician in attendance within 30 days preceding death.
h. When a physician refuses to sign the death certificate.
i. When a physician cannot be obtained within 24 hours of death.

Violations of the above are punishable by fine or imprisonment.

2. Treatment of automobile accident injuries?

No, unless there is a death.

3. Drowning?

Yes.

4. Gun shot wounds?

No, except where death results.

5. Hunting accidents?

No, except where death results.

6. Industrial accidents?

No, except where death results.

7. Industrial diseases?

Yes, to the Division of Health, Department of Health and Social Services, for diseases as required by statute or regulation.

8. Suicide attempts?

No; only death by suicide is reportable.

9. Sending of corpses to undertaker?

Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. Live births?

Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful. Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Division of Health, Department of Health and Social Services.

11. Communicable diseases?

Yes, to local health authorities, except for polio which must be reported locally and to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

12. Venereal diseases?

Yes, to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

13. Cancer?

Yes, to the Department of Health and Social Services.

14. Tuberculosis?

Yes, to your local Board of Health.

15. Chronic alcoholics?

No, even if you know or believe it probable that they are driving automobiles.

16. Epileptics?

No. But see article on page 68 of the June 1974 Blue Book issue.

17. Drug addiction?

No.

18. Abused or neglected children?

Yes. The law requires reports of "abused" or "neglected" (those not receiving food, clothing, shelter or care, including medical care so as to "seriously endanger" the child's health) children or those with exceptional educational needs (see article page 39). Wilful failure to report may subject a physician to a penalty; good faith reports provide immunity.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The law prohibits a physician from disclosing, except as specifically required or authorized by law, any information which he acquired in attending a patient and which is necessary for him to treat that patient. Information provided to the Division of Health which relates to personal facts about a patient may be used only for statistical or summary purposes or anonymously except as its disclosure may be necessary to provide services for the patient.

The use of consent and related forms for physicians

PREFACE

The forms referred to in this article are those which a physician may have occasion to use in his regular everyday practice. Since the forms were printed in the January 1970 "Blue Book" issue of the *Wisconsin Medical Journal,* they will not be reprinted here except for a few examples. Any physician wishing "sample" copies of these forms may obtain them upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701; or telephone 257-6781 in the Madison area or toll-free in Wisconsin 1-800-362-9080. These forms will frequently need to be adapted for a particular situation. Each physician should review them carefully before using them to make sure that they reflect the realities of a specific situation.

The forms, as printed in the January 1970 "Blue Book" issue and as listed in the box below, and the text in this article have been prepared by legal counsel for the State Medical Society of Wisconsin, and reflect changes in the laws and courts in Wisconsin since the previous publication in January 1970.

The forms listed in the box below do not cover every possible situation where a consent should be obtained. Additional forms are contained in a publication of the American Medical Association called *Medico-legal Forms with Legal Analysis, 1976.* The Society attorneys suggest that any forms that a physician might wish to use outside of the forms referred to in this article be checked with the physician's personal attorney to determine their legal adequacy.

Finally, the forms do not cover those procedures which are normally done in a hospital. The Wisconsin Hospital Association has a publication entitled *Consent Manual.*

CONSENT FORMS FOR PHYSICIANS

FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing "sample" copies of these forms may obtain them upon request to the *Wisconsin Medical Journal,* Box 1109, Madison, Wisconsin 53701; or tel. 608/257-6781. (Member physicians in Wisconsin may dial toll-free number: 1-800-362-9080.) Form numbers and titles as they appeared in 1970 are listed below for easy reference when requesting such forms. These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6: Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
Form 11: Consent to taking of photographs.
Form 12: Consent to publication of photographs.
Form 13: Authority to admit observers.
Form 14: Consent to taking of motion pictures of operation.
Form 15: Consent to televising of operation.
Form 16: Statement of need for therapeutic abortion.
Form 17: Authorization to treat condition of recent or partial abortion.
Form 18: Artificial insemination homologous consent.
Form 19: Aid consent.
Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation.
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
Form 26: Consent to operation.
Form 27: Consent to operation for cosmetic purposes.
Form 28: Consent to removal of tissue for grafting.
Form 29: Consent to operation and grafting of tissue.
Form 30: Order for taking of x-ray films.
Form 31: Consent to x-ray therapy.
Form 32: Permission to use radioisotopes.
Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
Form 38: Agreement with blood donor.
Form 39: Release and receipt (blood donor).
Form 40: Consent to disposal of amputated part of organ.
Form 41: Gift of part of body under Wisconsin Uniform Anatomical Gift Act of 1969.
Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of dead fetus.

2. Termination of contract

Care must be taken to inform the patient appropriately, but unmistakably when the patient-physician relationship is terminated. What should be done depends upon how the situation arises.

a. Former patient

If you have a former patient who calls and wishes further services, and you do not wish to further treat that patient, you should make your decision clear. Following such conversation you should confirm it by a letter. Form 1, with its enclosure, Form 2, is appropriate and gives the physician a record for his file. (These forms appear as "examples" on page 26.)

b. Withdrawal from a case

There may be occasions where a physician does not wish to continue on a case. Consistent with legal as well as ethical principles he must find appropriate steps to withdraw. He cannot just stay away and not notify the patient. This would be abandoning the patient and could subject the physician to a suit for damages.

FORM 1

LETTER TO FORMER PATIENT WHERE PHYSICIAN DOES NOT WISH TO TREAT LATER ILLNESS

Dear _____:

This letter is to confirm our conversation of _____ _____ (date).

At that time I informed you that I could not accept you as a patient for your present illness. I suggested to you that you contact another physician and I urge you to do so now if you have not already done so.

Since I have treated you for a previous condition, I have records which your new physician can use. Upon receipt of your written approval, I will make available to your new physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

For your convenience I enclose a form that you may use to give me such written approval.

Very truly yours,

_____M.D.

(Enclose Form 2)

FORM 2

AUTHORIZATION TO DISCLOSE INFORMATION TO NEW PHYSICIAN

I authorize _____, M.D., my former physician, to disclose complete information to my present physician, _____, M.D., concerning medical findings and treatment from about _____ 19____ until the date of this authorization.

Signed _____

Place _____

Date_____

Witness _____

Witness _____

He must give the patient proper notice that he is withdrawing from the case and must give the patient a reasonable amount of time to obtain a new physician. What is a reasonable amount of time will depend upon the circumstances of the case and the availability of other physicians in the area. We suggest that under most circumstances that the time set forth be not less than five (5) days. To provide a record and protect the physician a letter should be sent to the patient. If the letter is sent by certified mail with a return receipt requested, the physician will have record in his file showing not only that the patient was notified, but also the date the patient received the notification. Form 3 (example on page 26) is appropriate for this purpose. We suggest that you may wish to enclose Form 2 with the letter for the patient's convenience.

c. Discharge of a physician

The patient may also terminate the contract by discharging the physician. The physician will want to make an immediate and adequate record that he did not abandon the patient. The physician may do well to try to obtain from the patient a signed statement of the facts and discharge of the physician. Where this is not available we suggest that the physician send a letter to the patient such as Form 4. Again, the enclosure of Form 2 is appropriate. We suggest the letter be sent by certified mail, with a return receipt requested so that your file will show receipt of the letter by the patient.

3. Special problems during treatment

There are many problems that can arise during the treatment of a patient. The ones covered in this section are of particular importance to the physician since, if no pro-

FORM 3

LETTER OF WITHDRAWAL FROM CASE

Dear Mr. _____:

I find it necessary to inform you that I am withdrawing from further professional attendance upon you for the reason that you have persisted in refusing to follow my medical advice and treatment.

Since your condition requires medical attention, I suggest that you place yourself under the care of another physician without delay. If you so desire, I shall be available professionally to attend you for a reasonable time after you have received this letter, either for regular or emergency medical treatment, but in no event for more than _____ days following such receipt. This should give you ample time to select a physician of your choice from the many competent practitioners in this area.

With your written approval, I will make available to this physician your case history and complete information regarding the diagnosis and treatment which you have received from me.

Very truly yours,

_____, M.D.

Enclosure Form 2

tective steps are taken and a record made of such steps, the defense against allegations of malpractice could be made considerably harder and more expensive.

a. Patient who fails to follow advice

Where a physician feels that a certain treatment or procedure should be done and the patient refuses, a record should be made. Form 5 may be adapted to the situation as it occurs.

b. Patient who fails to keep appointment

If a patient fails to keep an appointment where the patient has a condition the physician knows needs treatment, the physician should make this fact known to the patient. The physician, at the same time, should see that his records reflect his professional advice to the patient. A letter such as Form 6 should be sent to the patient.

c. Patient who leaves hospital against medical advice

Cases arise where patients refuse to remain in a hospital even though their physician feels that continued hospitalization is necessary. Form 7 (example on page 27) provides a statement that the patient may sign which will release liability for the patient's acts. The physician should have two witnesses with him at the time he informs the patient of the reasons the physician feels indicate the need for continued hospitalization. These witnesses should sign the form whether the patient signs the form or not. If the patient refuses to sign, that fact should be noted on the form. The physician should have a copy of the form for his office records. The hospital will also want a copy for its records.

d. Substitute physician in obstetrical cases

It is not unusual for a physician to be unable to be present at a delivery, even though the physician would wish to be there. Another delivery might be in progress or the speed of delivery might make it impossible for the physician to get to the place of delivery. The physician should explain this to his obstetrical patient when she first comes to his office. The physician should have the expectant mother sign a form such as Form 8 as an acknowledgment of the fact that she understands and agrees.

e. Office treatment

Some procedures can be done either in the physician's office or in the hospital. Where the physician decides to do the procedure in his office he should inform the patient of the alternatives and any special risks involved. If the patient decides that the procedure should be done in the hospital, the physician should not attempt to do the procedure in his office. If the patient does agree to having the procedure in the office, then the physician should have the patient sign a consent such as Form 9.

4. Confidential and privileged relationship

In Wisconsin, communications between a patient and his physician are protected both by law and ethics.

Under Wisconsin law, certain disclosures made by a patient to his physician in order to give the physician sufficient information to enable him to treat the patient are "privileged." This "privilege" means that the statements cannot be disclosed by the physician unless the patient allows it or unless the physician is allowed or required by law to disclose them. The "privilege" is that of the patient, and can ordinarily be claimed or released only by the patient.

Confidential communications involve a physician's ethical duty to keep secret the information he has obtained about a patient while acting in his professional capacity. This obligation is independent of the privilege discussed in the preceding paragraph. It is binding on the physician at all times.

Wisconsin Statutes permit the right of an employee or the employee's designated representative to inspect personal medical records concerning the employee contained in the employer's file. If the employer believes that disclosure of an employee's medical records would have a detrimental effect on the employee, the employer may release the medical records to the employee's physician or through a physician designated by the employee, in which case the physician may release the medical records to the employee's immediate family.

Unauthorized disclosure of confidential information can be grounds for revocation of the physician's license. It may also be the basis for a suit for damages by the patient. Each physician therefore must exercise care to protect against unauthorized disclosure of confidential or privileged information.

FORM 7

STATEMENT OF PATIENT LEAVING HOSPITAL AGAINST MEDICAL ADVICE

This is to certify that I am leaving _____ Hospital at my own insistence and against the advice of my attending physician and hospital authorities. I have been informed by them of the dangers attendant on my leaving the hospital at this time. I assume all responsibility for any results caused by leaving the hospital prematurely, and I hereby release my attending physician and the hospital, its employees and officers from all liability for any and all conditions, complications and results.

_____

I hereby agree to hold harmless my attending physician and the _____ Hospital, its employees and officers, from all liability of whatsoever nature, with reference to the discharge of the patient named above.

_____
(husband, wife, parent, etc.)

Date _____
Signed in the presence of:
Witness _____
Witness _____

NOTE: If the patient refuses to sign such a statement, he cannot be forced to do so, legally, nor may his release be withheld until he signs. If this occurs, the form should be filled out, witnessed by the hospital personnel present, and the statement made on the form "signature refused."

a. Release of patient health care records

By earlier case law and now by statute, a patient's health care records (all records related to the health of a patient prepared by or under the supervision of a health care provider) may ordinarily only be released on the authorization of the patient or one legally permitted to act for the patient. The law defines "informed consent" with respect to the disclosure of information from a patient as written consent "containing the name of the patient whose record is being disclosed, the purpose of the disclosure, the type of information to be disclosed, the individual, agency or organization to which disclosure may be made, the type of health care providers making the disclosure, the signature of the patient or the person authorized by the patient, the date on which the consent is signed and the time period during which the consent is effective." Wis. Stats. §146.81 (2). In making a release of medical records, the physician should very carefully review the authorization to assure that the release is made strictly in accordance with the authorization.

(1) Access without informed consent. Release of medical records without patient authorization, unless specifically permitted by law, is a breach of confidentiality and may subject the physician to a lawsuit. The law permits the release of patient health care records upon request without informed consent in the following circumstances:

(a) To staff, accreditation or review committees.

(b) For performance of health care services to persons providing such services (including emergency care) or being consulted in regard to such services.

(c) For billing, collection, and payment of claims.

(d) Under court order.

(e) On written request from an appropriate government agency.

(f) For research purposes under specific conditions.

FORM 16

STATEMENT OF NEED FOR THERAPEUTIC ABORTION

We find from observation and examination of _____ _____ that she is pregnant, that she is suffering from the following ailment or condition: _____, and that it is medically necessary to perform a therapeutic abortion upon her. Further progress of her pregnancy would gravely endanger or imperil her life. We therefore recommend that a therapeutic abortion be performed.

Date _____

(1) _____

(2) _____

(3) _____

(duly licensed physicians)

NOTE: An abortion is not a crime when performed for therapeutic purposes, that is, when it is necessary to save the life of the patient. The physician should be in a position to establish the therapeutic ground upon which he justified action. In order to best protect himself in this regard, he should obtain and preserve in his file a statement such as the above, signed by at least three reputable physicians (including himself) that they have examined the patient and are of the opinion that an abortion is a medical necessity.

(2) Patient access to health care records. Any patient or other person may, upon submitting a statement of informed consent, (a) inspect the patient's records during regular business hours upon reasonable notice, (b) receive a copy of the patient's records on payment of reasonable costs, (c) receive a copy of the patient's x-ray reports or have the patient's x-ray films referred to a provider of his choice for analysis upon payment of reasonable costs. Wis. Stats. §146.83.

b. Photographs

Physicians may wish to make a visual record of a case for several reasons. In cosmetic surgery it may show the result of the surgery. In other cases it may show the result of a particular method of treatment. It may also be used for unusual cases where documentation would be valuable for teaching purposes. In any of these cases there must be a release of the confidential or privileged relationship to allow the taking of photographs.

c. Observers, motion pictures, television

In cases similar to those where photographs may be desirable, there are cases which should be observed, televised or recorded on film. The release of the confidential or privileged relationship must also be obtained in these cases. Forms 13, 14 and 15 may be used for these situations.

VI. Special situations

There are certain procedures which the physician should approach with caution and be sure to take the necessary steps to document what has happened and, to be sure that he proceeds only with proper authority.

1. ABORTIONS

Under Wisconsin Statutes there are limited situations in which an abortion may be legally performed. One of these is the therapeutic abortion and Form 16 (example on page 28) provides the record necessary to meet the requirements of Wisconsin Statutes for such a procedure. Form 17 is a model for a statement by a patient to be used in connection with the treatment of a recent or partial abortion.

The law as it regards abortion is currently unsettled. While Wisconsin Statutes strictly limit the conditions under which an abortion may be performed, this statute, at least as to certain factual applications, has been ruled unconstitutional. It is recommended that prior to conducting any abortions each physician consult his personal attorney as to the legality of his proposed course of action.

2. ARTIFICIAL INSEMINATION

There are two types of artificial insemination. First where the husband's semen is used and, second, where the semen of a male other than the husband is used.

a. Artificial insemination—homologous

AIH involves the use of the husband's semen to attempt to make the wife pregnant. A consent should be signed by both the husband and the wife. Form 18 can

be used for this purpose. It is believed there is no legal complication for this situation.

b. Artificial insemination—donor

AID involves the use of the semen of a male other than the husband. In such cases there are persons other than the husband and wife to consider, namely, the donor, and if he be married, his wife.

The husband and wife must consent. Form 19 provides for this.

In this situation we also recommend that the donor and his wife execute consents such as Forms 20 and 21.

There is a diversity of opinion on the legality and morality of this type of artificial insemination. It is recommended that prior to the use of these forms each physician consult his personal attorney.

3. STERILIZATION

In Wisconsin, neither therapeutic nor non-therapeutic sterilization is a crime according to a 1968 opinion of the State Attorney General. Sterilization can result from three separate situations.

a. Sterilization as a result of an operation for other purposes

Some cases can result in sterilization, although the purpose of the operation is not to achieve sterilization. This risk must be explained to the patient in terms that he can understand. Then the physician should have the patient sign a separate consent form for this express purpose. Form 22 can be used for this purpose. The spouse should be urged to sign the consent. This is to avoid later statements by the spouse that he or she knew nothing about the possibility of sterilization.

b. Therapeutic sterilization

Medical reasons exist for operations which are intended to sterilize the patient. In such cases a consent should be obtained from both the husband and the wife. Form 23 can be used for this procedure.

c. Non-therapeutic sterilization

Requests for non-therapeutic sterilization should be the subject of a conference with both the husband and the wife. The nature of the operation, the fact that it cannot be guaranteed as 100% effective, should all be explained in detail. Then, if they wish to proceed, a consent such as Form 24 should be signed.

VII. Other consent forms

There are other forms included in the January 1970 "Blue Book" printing that may be of common use to a physician. These forms are believed not to require explanatory text. However, before any of these forms are signed, the physician should review the requirements for a valid consent given earlier in this article. ■

A brochure, "Alcohol and Your Unborn Baby" (in English and Spanish versions), published by the State Medical Society of Wisconsin for physicians and patients now is available in quanity by writing to:

The Communications Department
State Medical Society of Wisconsin
P. O. Box 1109
Madison, Wisconsin 53701

Prepared and distributed by the State Medical Society of Wisconsin

MEDICAL EXAMINING BOARD—Chapter Med 10

UNPROFESSIONAL CONDUCT DEFINED

Med 10.01 Authority and purpose. The definitions of this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.08, and 448.40, Stats., for the purposes of ch. 448, Stats.

Med 10.02 Definitions. (1) For the purposes of these rules:

(a) "Board" means the medical examining board.

(b) "License" means any license, permit, certificate, or registration issued by the board.

(2) The term "unprofessional conduct" is defined to mean and include but not be limited to the following, or aiding or abetting the same:

(a) Violating or attempting to violate any provision or term of chapter 448 of the statutes or of any valid rule of the board.

(b) Violating or attempting to violate any term, provision, or condition of any order of the board.

(c) Knowingly making or presenting or causing to be made or presented any false, fraudulent, or forged statement, writing, certificate, diploma, or other thing in connection with any application for license.

(d) Practicing fraud, forgery, deception, collusion, or conspiracy in connection with any examination for license.

(e) Giving, selling, buying, bartering, or attempting to give, sell, buy, or barter any license.

(f) Engaging or attempting to engage in practice under any license under any given name or surname other than that under which originally licensed or registered to practice in this or any other state. This subsection does not apply to change of name resulting from marriage, divorce, or order by a court of record.

(g) Engaging or attempting to engage in the unlawful practice of medicine and surgery or treating the sick.

(h) Any practice or conduct which tends to constitute a danger to the health, welfare, or safety of patient or public.

(i) Practicing or attempting to practice under any license when unable to do so with reasonable skill and safety to patients.

(j) Practicing or attempting to practice under any license beyond the scope of that license.

(k) Offering, undertaking, or agreeing to treat or cure a disease or condition by a secret means, method, device, or instrumentality; or refusing to divulge to the board upon demand the means, method, device, or instrumentality used in the treatment of a disease or condition.

(l) Representing that a manifestly incurable disease or condition can be or will be permanently cured; or that a curable disease or condition can be cured within a stated time, if such is not the fact.

(m) Knowingly making any false statement, written or oral, in practicing under any license, with fraudulent intent; or obtaining or attempting to obtain any professional fee or compensation of any form by fraud or deceit.

(n) Wilfully divulging a privileged communication or confidence entrusted by a patient or deficiencies in the character of patients observed in the course of professional attendance, unless lawfully required to do so.

(o) Soliciting or attempting to solicit patients, directly, indirectly, or by agents.

(p) Administering, dispensing, prescribing, supplying, or obtaining controlled substances as defined in s. 161.01 (4), Stats. otherwise than in the course of legitimate professional practice, or as otherwise prohibited by law.

(q) Having a license, certificate, permit, or registration granted by another state to practice medicine and surgery or treat the sick limited, restricted, suspended, or revoked, or having been subject to other disciplinary action by the licensing authority thereof.

(r) Conviction of any crime which may relate to practice under any license, or of violation of any federal or state law regulating the possession, distribution, or use of controlled substances as defined in s. 161.01 (4), Stats. A certified copy of a judgment of a court of record showing such conviction, within this state or without, shall be presumptive evidence thereof.

(s) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any amphetamine, sympathomimetic amine drug or compound designated as a schedule II controlled substance pursuant to the provisions of ch. 161 Stats. to or for any person except for the treatment of narcolepsy, or for the treatment of hyperkinesis, or for the treatment of drug induced brain dysfunction, or for the treatment of epilepsy, or for the differential diagnostic psychiatric evaluation of depression, or for the treatment of depression shown to be refractory to other therapeutic modalities, or for the clinical investigation of the effects of such drugs or compounds in which case an investigative protocol therefore shall have been submitted to and reviewed and approved by the board before such investigation has been begun. ■

Wisconsin Administrative Code

MEDICAL EXAMINING BOARD—Chapter Med 8

PHYSICIAN'S ASSISTANTS

Med 8.01 Authority and purpose. The rules in this chapter are adopted by the medical examining board pursuant to the authority delegated by ss. 15.08 (5), 227.08, 444.04 (1) (f) and 448.40, Stats., and govern the certification and regulation of physician's assistants.

Med 8.02 Definitions. (1) "Board" means the medical examining board.

(2) "Council" means the council on physician's assistants.

(3) "Certificate" means documentary evidence issued by the board to applicants for certification as a physician's assistant who meet all of the requirements of the board.

(4) "Educational program" means a program for educating and preparing physician's assistants which is approved by the board.

(5) "Individual" means a natural person, and does not include the terms firm, corporation, association, partnership, institution, public body, joint stock association, or any other group of individuals.

(6) "Supervision" means to co-ordinate, direct, and inspect continually the accomplishments of another, or to oversee with powers of direction and decision the implementation of one's own or another's intentions.

(7) "Patient services" means any or all of the following:

(a) The initial approach to a patient of any age in any setting to elicit a personal medical history, perform an appropriate physical examination, and record and present pertinent data in a manner meaningful to the physician.

(b) Performing, or assisting in performing, routine diagnostic studies as appropriate for a specific practice setting.

(c) Performing routine therapeutic procedures including but not limited to injections, immunizations, and suturing and care of wounds.

(d) Instructing and counseling patients on physical and mental health including but not limited to diet, disease, treatment, and normal growth and development.

(e) Assisting the physician in the institutional setting by assisting at surgery, making patient rounds, recording patient progress notes, compiling and recording detailed narrative case summaries, and accurately writing or executing standing orders or other specific orders following consultation with and at the direction of the supervising physician. Countersignature of records must be consistent with institutional regulations.

(f) Assisting in the delivery of services to patients by reviewing and monitoring treatment and therapy plans.

(g) Independently performing evaluative and treatment procedures necessary to provide an appropriate response to life threatening emergency situations.

(h) Facilitating referral of patients to other appropriate community health facilities, agencies, and resources.

Med 8.03 Council: powers, meetings, records. The council shall exercise such powers as are or may be provided to it by the laws of the state of Wisconsin pertaining to the education, certification, and regulation of physician's assistants. The council shall propose to the board such rules not inconsistent with the law, as it deems necessary and proper for the execution and enforcement of such laws. The council shall meet at least 4 times in each calendar year. The chairman, or other presiding officer of the council, may call special meetings thereof when, in the judgement of such chairman or other presiding officer, circumstances or functioning of the council so require. The chairman, or other presiding officer of the board, may call special meetings of the council when, in the judgement of such chairman or other presiding officer, circumstances or functioning of the council or of the board so require. The secretary shall maintain an accurate record of all proceedings of the council.

Med 8.04 Certifying educational programs. The board shall conduct an investigation prior to approving any educational program which prepares physician's assistants. The examining board may designate an agent and one or more examining board members and one or more council members to conduct a portion or all of such investigation to determine the facts upon which the examining board shall make its decision. Any party aggrieved by the decision of the examining board under this section may, within 20 days of notice thereof, apply for a formal hearing before the board or an agent duly appointed to sit for the board. The decision of the board shall comply with s. 227.13, Stats., and may be reviewed as provided in s. 227.16, Stats.

Med 8.05 Practice: scope and limitations. In providing patient services the entire practice of a physician's assistant shall be under the supervision of a licensed physician. The scope of practice of a physician's assistant shall not exceed the definitions of "patient services" as set forth in Med 8.02 (7) Wis. Adm. Code, nor the physician's assistant's training

and experience, nor the scope of practice of the supervising physician. No physician's assistant shall redelegate a task delegated to such physician's assistant by the supervising physician.

Med 8.06 Employe status. No physician's assistant shall be self employed. If the employer of a physician's assistant is other than a licensed physician, such employer shall provide for and not interfere with the supervision required in Med 8.05 Wis. Adm. Code.

Med 8.07 Employment limitation: supervising physician responsibilities. (1) No physician may supervise more than 2 physician's assistants, but a physician's assistant may be supervised by more than one physician. In the case of exceptions to this rule, a written plan for the supervision of more than 2 physician's assistants by a licensed physician must be filed with, reviewed, and recommended for approval by the council, and approved by the board.

(2) Another licensed physician may be designated by the supervising physician to supervise a physician's assistant for periods not to exceed 8 weeks per year. Except in an emergency, such designation shall be made in writing to the substitute supervising physician and to the physician's assistant, and must be executed and a copy thereof filed with the council prior to the supervising physician's absence.

(3) A physician's assistant may practice on premises away from the main office of the supervising physician or an institution where the supervising physician has staff privileges, providing that the supervision required in Med 8.02 (6), Wis. Adm. Code, is maintained. The physician's assistant must be able to contact either at first hand or by telephone, radio or television the supervising physician or designated substitute physician within 15 minutes at all times. The physician shall review and countersign all notes made by the physician's assistant at least weekly. A supervising physician must visit locations attended by a physician's assistant no less than every 3 months. Patients in locations other than the location of the supervising physician's main office shall be attended personally by the physician consistent with their medical needs.

Med 8.08 Qualification, application, examination, re-examination. (1) To be qualified for admission to examination for certification as a physician's assistant in this state, an applicant must supply evidence satisfactory to the board that the applicant:

(a) Is of good professional character.

(b) Has successfully completed a formal physician's assistant educational program approved by the board. Until January 1, 1980, the board may waive this requirement for an applicant who has been employed in practice as a physician's assistant, as defined in these rules for 24 consecutive months during the 3 calendar years preceding January 1, 1975.

(2) Every person applying for certification as a physician's assistant shall make application therefor on forms provided for this purpose by the board and shall submit to the board the following:

(a) A completed and verified application form.

(b) An unmounted photograph, approximately 8 by 12 cm., of the applicant taken not more than 60 days prior to the date of application and bearing on the reverse side the statement of a notary public that such photograph is a true likeness of the applicant.

(c) A verified statement that the applicant is familiar with the state health laws and the rules of the department of health and social services as related to communicable diseases.

(3) Having complied with sub. (2), the applicant shall be examined. Examination may be both written and oral. The council shall advise the board as to content of the examinations required under this subsection and passing grades therein, and the board shall provide for such content and such passing grades. In lieu of its own examinations, the board may make such use as it deems appropriate of examinations prepared, administered, and scored by national examining agencies. The board designates the council as its agent for conducting examinations.

(4) The board will notify each applicant found eligible for examination of the time and place scheduled for that applicant's examinations. Failure of an applicant to appear for examinations as scheduled will void that applicant's application and require the applicant to reapply for certification, unless prior scheduling arrangements have been made with the board by the applicant. At the opening of the examinations, each applicant will be assigned a number which shall be used by the applicant on all examination papers, and neither the name of the applicant nor any other identifying marks shall appear on any such papers. At the opening of the examinations the proctor will read and distribute to the assembled applicants the rules of conduct to be followed during the course of the examinations. Any violation of these rules of conduct by any applicant will be cause for the board to terminate the examination of such applicant and to exclude such applicant from continuing the examinations, and will also be cause for the board to find that such applicant has failed the examinations.

(5) An applicant who fails to achieve a passing grade in the examinations required under this chapter may apply for re-examination on forms provided for that purpose by the board. For each such re-examination the application therefor shall be accompanied by the re-examination fee. An applicant who fails to achieve a passing grade in the examinations required under this chapter may be re-examined twice at not less than 4 month intervals, and if such applicant fails to achieve a passing grade on the second such re-examination, that applicant shall not be admitted to

further examination until such applicant reapplies for certification and also presents to the board evidence of such further professional training or education as the board may deem appropriate in such applicant's specific case.

(6) There is no provision for waiver of examination or for reciprocity with other licensing jurisdictions under these rules.

(7) At the time of initial certification and at the time of each biennial registration thereafter, each physician's assistant shall list with the board the name and address of the supervising physician and shall also notify the board of any change of supervising physician within 20 days following such change.

Med 8.09 Exclusions. None of the provisions of this chapter shall be construed to permit the independent prescribing or dispensing of any drug, or the practice of acupuncture in any form, by any physician's assistant.

Med 8.10 Temporary certificate prior to permanent certificate. (1) An applicant for certification to practice as a physician's assistant may apply to the board for a temporary certificate to practice as a physician's assistant if the applicant:

(a) Is a graduate of an approved school and applies for the temporary certificate not less than 30 days prior to the date set for the national certifying examination for primary care physician's assistants; or

(b) Provides proof of having successfully completed the national certifying examination for primary care physician's assistants, and applies for the temporary certificate not less than 30 days prior to the date set by the board for holding its next oral examinations for certification as a physician's assistant.

(2) Following review by a council member of the applications and required documents for permanent and temporary certification and a finding by the member that the applicant is qualified for admission to the examination for permanent certification to practice as a physician's assistant, the council member, on behalf of the board, may issue a temporary certificate to practice as a physician's assistant to the applicant.

(3) The fee specified in s. 440.05 (6), Stats., must accompany the application for the temporary certificate and all remittances must be made payable to the Wisconsin medical examining board.

(4) (a) Except as provided in par. (b), a temporary certificate to practice as a physician's assistant expires 30 days after the completion of the next oral examination for permanent certification or on the date the board grants or denies the holder of the temporary certificate a permanent certificate, whichever is later.

(b) A temporary certificate expires on the first day of an oral examination for a permanent certificate if the holder of the temporary certificate is required to take the oral examination and fails to apply for the examination.

(5) A temporary certificate to practice as a physician's assistant shall be issued only once to each applicant. ■

PREMARITAL EXAMINATIONS

THE EXTENT of physical examinations given couples under the state requirements stated in Section 745.60, Wisconsin Statutes, has caused some concerns by the State Registrar's Office and the County Clerks Association. Recently the Dane County Medical Society Board of Trustees issued a statement in its *Bulletin* setting forth what the Board considers as complying with the state requirement in premarital examinations.

"(1) RPR or VDRL or similar serologic test for syphilis; (2) An examination of the anogenital area for evidence of venereal disease; (3) As indicated, cultures taken for gonorrhea, smear or culture taken for herpes progenitalis, a scraping for confirmation of a diagnosis of scabies, possible biopsy or removal of venereal warts or perhaps other cultures as appropriate to rule out other significant sexually transmitted diseases; and (4) A limited office examination is appropriate as determined by the physician's judgment."

The *Bulletin* article further stated that "the Dane County Medical Society Board of Trustees feels that the practice of giving complete physical examinations or representing complete physical examinations as mandatory as part of statutory requirements is wrong. It is understood that certain patients will request complete examinations by their physicians; however, no misrepresentation may be made by examining physicians. The Dane County Clerk has been asked to report to DCMS any specific instances in which physical examinations appear to be more complete or otherwise outside the above stated guidelines for investigation. Meanwhile, a committee of county government representatives and a physician representing the State Medical Society is studying the potential for removing the specifics of examination, laboratory, and certificate from the statutes. These would be included in an administrative rule, allowing flexibility as technology and disease patterns change."

INFANT EYE DROP RULE

THE PERMANENT ADMINISTRATIVE rule allowing the use of either silver nitrate, tetracycline, or erythromycin for the prevention of gonococcal ophthalmia in newborn infants became effective October 1, 1980. The new rule, which is identical to the emergency rule which expired October 12, 1980, also changes the time frame in which the preventive agent must be administered after birth from "immediately" to "as soon as possible, but not later than one hour after birth." Under the rule, only one child shall be treated per container.

STATE DEPARTMENT OF REGULATION & LICENSING

Verification policy for physician licensure

FOR SOME YEARS a number of hospitals and clinics have asked the Department of Regulation & Licensing to verify their entire list of medical staff members on an annual basis. This was a service performed by the Medical Board staff at a time when the number of Wisconsin licensees was considerably less than the current 13,000 (physicians, physical therapists, osteopaths, physician's assistants, and podiatrists). In February 1981 the Department announced that it could no longer provide this service to that extent.

The Department offers several avenues available to verify the licensure of medical professionals.

A. Purchase of the Department's current master printout of licensees (name, address, and license number) at a cost of about $60 for all licensees of the Medical Examining Board. Contact the Department's Renewal Section at (608) 266-0627 for further information and ordering.

B. Purchase of the Department's directory of Medical Board licensees which is current up to October 1980, contains no license numbers, and costs $5.20.

C. Checking, at the physician's facility, the current registration card of all Medical Board licensees. That certificate, stamped "valid to December 1981," is the physician's proof of good standing with the Medical Examining Board.

D. Writing or calling the Medical Board office when the following is true:
   1. Applicant for staff privileges is not listed in the printout or directory.
   2. Applicant for staff privileges does not produce a current registration card.
   3. Applicant is a new licensee in Wisconsin.
   4. A person has good reason to believe the Medical Examining Board has disciplined the licensee and verification of that fact is desired.

Some administrators and chiefs-of-staff have voiced concern that they will be unaware of the disciplined status of a physician whose license has been revoked, suspended, or limited. The Department has stated that this is unlikely since the Department issues press releases on all disciplinary actions and sends a *Digest of Rules & Discipline* to all licensees (including chiefs of medical staff and nursing supervisors). However, to alleviate any further uncertainties the Department has instituted a policy whereby it makes disciplinary actions known to local newspapers and to all hospitals within the state. If a person wishes clarification beyond that information, the Department of Regulation & Licensing (Ann J Haney, Secretary of the Department, and Kaye Exo, Director of the Bureau of Health Professions) will verify the status of disciplined Medical Examining Board licensees upon request. Although they will respond to telephone calls, they would prefer to receive the request in writing.

Physicians who have been members of a hospital or clinic medical staff for a number of years will be expected to show their license "renewal card" every two years to the staff.

A physician experiencing no problems on a medical staff, having a current renewal card, and not listed in the *Digest* will not show up as a problem on the Department's records, Ms Haney states.

The Department of Regulation & Licensing and the Medical Examining Board have told the State Medical Society that they wish to assure effective regulation of the profession to the citizens of Wisconsin and, therefore, are most anxious to assist physicians in the verification process. ■

NOTICE

Wisconsin hospital emergency rooms and outpatient facilities are aware of the following federal and state laws which prohibit . . .

I. Discrimination against patients

Alcohol abusers, alcoholics and drug abusers who are suffering from medical conditions shall not be discriminated against in admission or treatment, solely because of their alcohol abuse, alcoholism or drug abuse by any private or public general hospital or outpatient facility [as defined in section 1633 (6) of the Public Health Service Act] which receives support in whole or in part by funds appropriated to any federal department or agency. Such regulations shall include procedures for determining if a violation of subsection (a) has occurred, notification of failure to comply with such subsection, and opportunity for a violator to comply with such subsection.

U.S.P.L. 91-616, Part C, Section 321 A & B and subsequent amendments

U.S.P.L. 92-255, Section 407 A & B and subsequent amendments

II. Refusal of admission

"A private or public general hospital may not refuse admission or treatment to a person in need of medical services solely because that person is an 'alcoholic,' 'incapacitated by alcohol,' 'or is an intoxicated person' as defined in subsection (2). This paragraph does not require a hospital to admit or treat the person if the hospital does not ordinarily provide the services required by the person. A private or public general hospital which violates this paragraph shall forfeit no more than $500."

Wis. Stats. 51.45 (15) (c)

PLEASE NOTE: Hospitals not equipped to admit or provide treatment to the person must have a written plan and agreement with the nearest hospital that provides services required by the person.

Any violation should be reported to the Bureau of Alcohol and Other Drug Abuse, 1 West Wilson Street, Room 434, Madison, Wisconsin 53702. Phone 608/266-2717.

Hospital liability risks not basis for usurping authority of medical staff

Donald P "Rocky" Wilcox
General Counsel, Texas Medical Association

A PRIMARY CONCERN of hospital governing boards is the risk of liability for the failure to maintain proper standards. Traditionally, hospital medical staff have had the primary duty of assuring proper medical care in the hospital. Recently some hospital governing boards have asserted that hospital liability risks for physician errors require that they dictate to medical staffs the terms and conditions of medical practice in hospitals. Such action cannot be legally justified where the medical staff has carried out its responsibility to adopt and adhere to quality care standards.

The number of disputes between hospital governing boards and organized medical staffs has been noticeable in the past few years. The basic issue in these disputes seems to center on whether or not the hospital administrator, as representative of the hospital governing board, has the legal right to dictate to its doctors the terms and conditions of their practice in the hospital. The "courts" are blamed as being the authoritative source for this position and the evidence most often cited is the Darling case (*Darling v. Charleston Community Memorial Hospital,* 211 NE 2d 253 [Ill Sup Ct., 1965]). With the Darling case as a base, "experts" assert that since the hospital is liable for the attending physician's mistakes, it must have the right to dictate to the medical staff what it believes are proper duties and responsibilities of the medical staff members. Since this is not what the Darling case stands for, a review of that case is in order.

Facts. The injured patient in Darling was an 18-year-old college student (Larry Darling) preparing for a career as a teacher-coach. As the son of the local Superintendent of Public Schools and nephew of the basketball coach for his college, he had promising career expectations.

On the first Saturday in November, he was playing defensive halfback for Eastern Illinois University and was injured during a play. After being treated by the team physician, he was sent to the emergency room of the small but JCAH-accredited Charleston Community Hospital. The only physician on emergency-room call that day was a 58-year-old general practitioner, who had not treated a major leg fracture for at least three years.

It was this physician who examined the student, had an x-ray film made, and determined that both bones below the knee in the right leg were broken. With the assistance of the nursing staff, the physician reduced the fracture and applied a plaster cast. The physician visited the student frequently while he remained in the hospital, but did not call in any specialist for consultation.

After three weeks, the student was transferred to a larger hospital and placed under the care of a well-known orthopedic surgeon. The orthopedic specialist found a considerable amount of dead tissue in the fractured leg, which he concluded was the result of interference with the circulation of blood caused by the cast. After several unsuccessful attempts to save the leg, it was amputated.

Litigation. The general practitioner and the hospital were sued. The physician settled the suit against him for $40,000. At the trial the issue was whether or not the hospital was liable for the boy's injuries. Evidence of professional negligence on the part of the physician and the nurses (the latter being clearly employees of the hospital) was demonstrated. The hospital was held to be liable in the amount of $110,000.

Analysis. This case is cited as authority for the statement that the hospital is responsible for the acts of independent private practitioners in the hospital; and, therefore, has the right to control their services. But note that in Darling, the physician involved was selected and provided by the hospital. It has been the law for many years that when a hospital selects the physician to treat a patient, it has the obligation to act wisely in the selection. The hospital then, in effect, provided a physician incompetent to perform the required tasks. Further, this was not truly an emergency situation. The boy had already been seen by the team physician prior to coming to the hospital. There was no imminent risk of death or loss of limb which compelled the general practitioner to immediately act rather than call a physician competent to perform the task. Therefore, although the physician may not have been an employee of the hospital, the common law principal-agent relation-

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ship was applied; that is, that the principal is liable for the negligent acts of his agents.

Subsequent cases. It is interesting to note that many of the reported cases in the various states since Darling (1965) have either rejected the case as legal precedent for holding the hospital liable for the acts of independent practitioners, or have followed it as precedent for hospital liability for physician employee negligence (principal-agent relationship) and categorized the physician in Darling as being an employee of the hospital for liability purposes.

One case rejecting Darling is *Collins v. Westlake Community Hospital* (299 NE 2d 326 [Ill App Ct, June, 1973]). In that case, the patient was a young boy who was struck by an automobile. He was taken to the hospital where he was examined by a physician employed by the hospital. The physician placed the boy's leg in moleskin traction. The boy's family physician, chosen by the family, examined the boy and then referred the case to the orthopedic department chairman at the hospital. The orthopedist was not an employee of the hospital.

The orthopedist examined the boy and reviewed the nurses' notes. He replaced the moleskin traction with a floating Thomas splint. The next day, the boy's foot was cool to the touch. An elastic bandage on the boy's leg was loosened and warmth temporarily returned to the leg. The following evening, the orthopedist was concerned with the boy's total loss of sensation in his foot. He requested consultation by a neurosurgeon.

The following morning the nurses on duty notified the orthopedist that the boy's foot was "cold and dusky in color." Two hours later the orthopedist arrived at the hospital and removed the traction. Not yet having received the neurosurgeon's report, he ordered immediate exploratory surgery. A blood clot was found in the femoral artery. A vascular specialist determined that the boy had irreversible ischemia of the leg. The following day, the boy's leg was amputated.

A lawsuit was filed against the hospital and the orthopedist. The boy's attorney, citing Darling, claimed that the hospital had a duty to review the medical care being provided him by the orthopedist. The trial court, however, ruled in favor of the hospital saying that, as a matter of law, the hospital was not liable. The issue of whether or not the orthopedist committed malpractice then went to the jury. After the jury held in favor of the orthopedist, the boy appealed.

In affirming the decision of the trial court, the appellate court ruled that the hospital did not have the legal duty to review the medical care provided a patient by the orthopedic surgery department chairman at the hospital. It then distinguished this case from the Darling decision.

It characterized the physician in Darling, who was held to have performed negligent treatment on the patient, as being "an employee of the hospital and subject to its direct supervision." The appellate court emphasized that, in this case, however, the orthopedist was selected by the patient and was *not* an employee of the hospital. It was the orthopedist who was "in charge of the case." Also, the court noted that the nurses were not negligent in performing their duties, whereas in Darling, they were.

The following statement taken from the opinion of the appellate court summarizes the Illinois Court's view of the role of the hospital in this case.

"The decision to treat a patient in the particular manner is a medical question entirely within the discretion of the treating physician, not the hospital."

Many other cases can be cited as authority for this rule of law. (See, for example, *St. John's Hospital Medical Staff v. St. John Regional Medical Center,* 245 NW 2d 472 [SD 1976], where unilateral action on the part of the hospital governing board to amend the medical staff bylaws, based in part on the hospital's perceived risk of liability for physician acts, was declared to be null and void.) In fact, there is not one single reported case in Texas nor in any other state in which a hospital has been held legally responsible for the negligence of an attending competent physician engaged in independent practice and selected by the patient. Thus, hospitals cannot properly use their risk of liability for physicians' mistakes to dictate to physicians terms of their professional practice in the hospital. *The rights, duties, and obligations of medical staffs and their members are negotiable.*

Quality of care. Quality of care is a joint responsibility. A hospital's primary objective—that of providing high quality patient care services for the community—can be achieved best if there is a close working relationship and effective cooperation between the two partners who share the responsibility for hospital operations:

A related issue was discussed in the 1974 Wisconsin Supreme Court case entitled *Just v. Misericordia Hospital,* 61 Wis. 2d 574. In *Misericordia* negligence was claimed on the part of certain physicians and a hospital in which their services were rendered. The hospital was found innocent of any negligence upon proof that it met JCAH accreditation standards and that it provided facilities, nursing care, and services of a quality equal to those customarily provided in its area. That those practicing in the facility may have been negligent does not create an inference of negligence by the hospital and any such negligence must be proved by direct evidence.

(1) The board of directors or trustees responsible for the business management, housekeeping, and prudent use of the hospital's resources; and

(2) An organized staff of physicians practicing within the hospital and responsible for the methodology and implementation of the system under which the resources of the medical community are used to provide the best attainable quality of medical care and service.

The courts have not been willing to require hospital boards to assume full responsibility for the practice of medicine, but have recognized the roles of both the board and the medical staff. Medical staffs which act responsibly in assuring that proper standards of patient care and quality medical services are provided within the hospital have been supported by the courts when challenges to their traditional roles have been attempted. ■

Jail health care in Wisconsin

IN THE EARLY 1970s a number of federal and state courts ruled that it was unconstitutional to deny adequate medical care to inmates in correctional institutions. The AMA was asked to define "adequate medical care" and responded by developing Standards for Health Services in Jails, in Juvenile Correctional Facilities, and in Prisons. The project is funded by the Law Enforcement Assistance Administration, the AMA, and the 23 participating state medical societies.

Since 1976 the State Medical Society of Wisconsin has been working with interested sheriffs' departments on a *voluntary* basis to develop health care systems using the AMA's Standards. New jail standards will be released in September 1981.

Thus far, the sheriffs of 30 Wisconsin counties have asked for help from SMS and 11 jails have been accredited by the AMA. In addition to accreditation, the SMS provides ongoing consultation. This consultation includes technical assistance emphasizing the use of existing community resources, such as the county nursing service and mental health and alcoholism counselors from the Unified Services Board.

Sheriffs have volunteered to participate in this project because it has proved to be not only humanitarian but also cost-effective. At least three medically related lawsuits never materialized when the lawyers discovered the jails were accredited and that appropriate care had been given to their clients.

The counties which are currently participating in the project or receiving consultation are: Adams, Brown, Clark, Columbia, Dane, Dunn, Douglas, Eau Claire, Grant, Green, Iowa, Juneau, Kenosha, LaCrosse, Lafayette, Manitowoc, Marinette, Milwaukee House of Corrections, Ozaukee, Pierce, Polk, Racine, Rock, Sheboygan, St Croix, Walworth, Washington, Waukesha, Winnebago, and Wood.

Interested physicians whose local county or jail is not participating may obtain further information by contacting the State Medical Society of Wisconsin, Attention Parks Reinhardt, PO Box 1109, Madison, Wis 53701; or phone 257-6781 in the Madison area or 1-800-362-9080 (toll-free) in Wisconsin. ■

Jail Health Care Technical Assistance Committee: Warren H Williamson, MD, Racine, *chairman;* Irwin J Bruhn, MD, Walworth; Paul R Glunz, MD, Beaver Dam; Pauline M Jackson, MD, LaCrosse; Eugene R Jonas, MD, Ellsworth; Clarence W Jordahl Jr, MD, Waukesha; and representatives from the following organizations: Council on Criminal Justice; State Bureaus of Alcoholism and Other Drug Abuse, Community Corrections, Institutional Health, and Mental Health, UW-Extension, Department of Governmental Affairs; Wisconsin League of Women Voters; Wisconsin Public Health Association; and Wisconsin Sheriff's and Deputy Sheriff's Association.

MINOR'S CONSENT

A common question from physicians throughout the state is under what circumstances may a physician provide medical services to a minor without parental consent.

As a general rule, consent for medical services to be provided to an unemancipated minor must be given by the minor's parent, guardian, or court-appointed sustaining parent. Under appropriate circumstances a court may give consent in lieu of a parent.

Emancipation occurs when a minor is no longer under parental care and custody. A common example of emancipation is marriage by a minor.

Wisconsin law also provides that a minor may receive diagnosis of and treatment for venereal disease without parental consent. Attempts to expand this law to cover other specific fields of medical care (abortion, contraception, and drug abuse) have been unsuccessful.

This area of the law, parental rights versus minors' right of privacy, is now quite active and physicians should be alert to rulings which bear on this conflict.

1982 SMS Annual Meeting: May 13-15
Milwaukee—MECCA and Hyatt Regency

Guidelines for Implementation of Joint Practice of Physicians and Nurses

Prepared by Joint Practice Committee of the State Medical Society of Wisconsin and Wisconsin Nurses Association. Approved by the Council of the State Medical Society of Wisconsin, March 5, 1977.

What is joint practice?

Nurses and physicians practicing together within the framework of their respective practice acts and other guidelines (such as joint practice statements issued by their professional organizations) who modify and develop their practice relationships and patterns to make each other's competence and contribution to health care more effective. The services provided to clients are complementary but not interchangeable either in responsibility or accountability. The collaboration includes both independent and cooperative decision-making and is based on the preparation and ability of each practitioner. The nurse may be in a satellite location, consulting with the physician in accord with mutually developed care protocols. A complete definition of joint practice would involve all health professions, the entire health delivery system, and even the concept of health.

The mere fact of working together does not necessarily constitute joint practice since the physician and nurse may not be practicing in a collaborative, collegial way.

What is a joint practice statement?

A joint practice statement embodies guiding principles and professional opinion on elements of joint practice by physicians and registered nurses in any setting. The authority of the Statement testifies to mutually agreed upon principles of practice. The Statement can be used to validate generally acceptable practices or patterns of care and to respond effectively and responsibly to new needs and methods of providing care.[1]

The Joint Practice Committee of the State Medical Society of Wisconsin and the Wisconsin Nurses Association developed a Joint Practice Statement in 1974 to assist physicians and nurses. The Statement accompanies these guidelines (see adjacent box). The Statement was approved by the House of Delegates of the State Medical Society and Wisconsin Nurses Association and formally endorsed by the State of Wisconsin Board of Nursing. The Medical Examining Board has officially recognized the need for the development of joint practice arrangements in accord with the principles enumerated in the Statement.

In addition to joint practice committees at the state level, the National Joint Practice Commission, composed of eight members each from the American Medical Association and the American Nurses Association, facilitates joint practice efforts nationally.

How are local joint practice committees established?

In each health care delivery setting involving the practice of registered nurses and physicians, it is advantageous to have them affiliate in joint practice committees to provide both with an organizational base, a collegial advisory group, and a channel of communication.[1]

If one physician and nurse are practicing together, they can constitute the joint practice committee. In larger settings membership should include nurse and physician representation and can extend to other health professionals and administrative personnel.

These local joint practice committees should establish written policies and standards of performance and review them periodically.[1] The committee also serves as an advisory and interpretive body to the various staffs in that setting.

Involvement in district, regional, and state joint practice efforts also is encouraged and helpful.

Are special credentials required for joint practice?

It is imperative that nurses in joint practice be educationally prepared and professionally competent for their extended function. They must be clinically competent and able to assume responsibility for their decisions and acts. Written evidence of the nurses educational preparation, experience, continuing education, and periodic evaluation should be on file and available for external review.

Educational programs for the preparation of registered nurse practitioners in extended roles should be developed by nursing in consultation with medicine and should be carried out, wherever possible, under the aegis of accredited educational institutions.[1]

Physicians need to examine their qualifications and readiness for joint practice, and not all nurses are professionally or personally prepared for such practice. Inadequacies in either professional are not conducive to success in joint practice.

How do the nurse and physician relate to each other in joint practice?

Interdependent relationships and willingness to reformulate roles are facilitated when practitioners are mature, experienced, and comfortable in their own role. Persons who need to define and defend professional territory and who operate with defensive attitudes are not good candidates for joint practice. The goal of joint practice is to improve health care, not to protect or pre-

serve professional prerogatives. The success of joint practice is dependent on the attitudes, sincerity, and commitment of the persons involved.

Time and experience together are required to develop knowledge of each other, trust, and confidence. Mutual confidence is the crux of the relationship and will be communicated to others.

Certain mechanisms can assist the development of the relationship such as using problem-oriented records, periodically reviewing cases together, developing care plans jointly, and formally evaluating the pattern of relating to each other and caring for patients.

How do patients accept joint practice?

The focus of joint practice is on the needs of the patient and how the practice arrangement can meet them. Patient choice and preference continue to be preserved. The evident concern for the patient is conducive to acceptance.

The mutual respect and confidence in each other displayed by the physician and nurse are key determinants in patient acceptance.

Joint practice has evolved to improve the quality, availability, and accessibility of health care. If these ends are being achieved, greater patient satisfaction should be a consequence.

How is the quality of patient care maintained and improved?

Nurses and physicians, through collaboration, have the greatest potential to improve the quality, and increase the quantity, of health care.

State Medical Society of Wisconsin and Wisconsin Nurses Association

Statement on Joint Practice

Approved by the Council of the State Medical Society of Wisconsin, May 18, 1974, and endorsed by the October 9-11, 1974 WNA House of Delegates and the State of Wisconsin Board of Nursing. The Medical Examining Board recognizes the need for the development of joint practice arrangements in accord with the principles enumerated in the Statement.

This Statement embodies guiding principles and professional opinion on elements of joint practice by physicians and registered nurses in any setting. The authority of the Statement testifies to mutually agreed upon principles of practice. The Statement can be used to validate generally acceptable practices or patterns of care and to respond effectively and responsibly to new needs and methods of providing care.[1]

The State Medical Society of Wisconsin and Wisconsin Nurses Association cannot through this Statement alter the legal authority of the physician or registered nurse. However, the application of the following principles of joint practice can substantially improve the quality, availability and accessibility of health care for the people of Wisconsin.

- The health and best interest of the recipients of care are foremost considerations in all practice arrangements.

- The degree of professional responsibility vested in the physician or registered nurse is related to education, experience, competence, and licensure. Each practitioner should perform only those acts for which that person has been prepared and has demonstrated ability to perform.

- Medical and nursing services are complementary but they are not interchangeable either in responsibility or accountability. Each practitioner is accountable and responsible for the quality of care rendered. Each practitioner is responsible for the maintenance and improvement of practice proficiency.

- Each practitioner should receive remuneration commensurate with qualifications and proficiency.

- Medical and nursing collaboration includes both independent and cooperative decision-making. Mutually developed protocols can clarify shared responsibilities and delegated functions.

- Educational programs for the preparation of registered nurse practitioners in extended roles should be developed by nursing in consultation with medicine and should be carried out, wherever possible, under the aegis of accredited educational institutions.

- It is advantageous to have physicians and registered nurses affiliate in joint practice committees in order to provide both with an organizational base, a collegial advisory group, and a channel of communication.

- In each health care delivery setting involving the practice of registered nurses and physicians, a joint practice committee should establish written policies and standards of performance. Such policies and standards should be reviewed periodically.

- It is important to maintain a flexible and innovative approach in the evolving role realignment of registered nurses and physicians. Differences in recipient populations, in how they are served, and in the composition of practitioners working in a setting, will influence what each practitioner regularly does.

1. In developing this Statement the joint position statements on practice of the following medical and nurses associations were consulted and utilized: California, Canada, Florida and Idaho.

The health and best interest of the patient remains the foremost consideration in all practice arrangements.[1]

Each practitioner is accountable to the patient and to each other for the quality of care rendered individually and collectively.

The local joint practice committee should establish written policies and standards of performance and systematically review those standards and resultant care periodically. Evidence of the review should be maintained. The committee should make recommendations for improvement of care and monitor their implementation.

Are protocols necessary?

Medical and nursing collaboration includes both independent and cooperative decision-making. Mutually developed protocols can clarify shared responsibilities and delegated functions.[1] Protocols are helpful for practical purposes, for insuring quality, and for legal reference if required.

Published protocols are increasingly available for reference in professional journals and books. Consultation also can be obtained for the development and review of protocols. Protocols should be reviewed and updated regularly.

A general protocol should be available which describes how the nurse and physician in that setting practice with each other.

How does joint practice affect professional liability?

The physician has definitive legal responsibility and ultimate accountability in matters of medical care. However, the nurse shares in this accountability and remains legally responsible for decisions and actions in the practice of nursing. Each practitioner should be properly identified to the patient.

All professionals are expected to exercise judgment about the limits of their individual competence. Each practitioner should perform only those acts for which that person has been prepared and has demonstrated ability to perform. Each practitioner is responsible for maintenance and improvement of practice proficiency.[1]

There is no evidence of an increase in malpractice suits stemming from joint practice. Joint practice can lessen malpractice concerns because of improved, complementary care and shared accountability.

The Joint Practice Statement is admissible as evidence in court. If the practitioners are observing the guidelines in the Statement, they are practicing the "best care available" at the time.

What is the legal base for joint practice?

Practice acts (licensing laws) were enacted in the public interest to safeguard care and are not primarily for the protection of the practitioner.

The present medical and nurse practice acts in Wisconsin permit joint practice. The nurse functions under the nurse practice act and not under the physician assistant portion of the medical practice act.

Practice acts are phrased in broad terms to accommodate changes and advances without the necessity for statutory revision. The National Joint Practice Commission recommends that "practice acts which are broad enough to permit flexibility within the confines of licensure be left as they are and that statements addressing themselves to the issues of role realignment and adjustment be initiated by State Joint Practice Committees or other joint bodies of medicine and nursing."[2]

A joint practice statement embodies guiding principles and professional opinion on elements of joint practice by physicians and registered nurses in any setting. The authority of the Statement testifies to mutually agreed upon principles of practice. The Statement can be used to validate generally acceptable practices or patterns of care and to respond effectively and responsibly to new needs and methods of providing care.[1]

The degree of professional responsibility vested in the physician or registered nurse is related to education, experience, competence, and licensure.[1]

How does joint practice affect the organization for care?

Both nurses and physicians should participate in committees which focus on patient care and the practice environment and organization. They also should be directly involved or represented in the administrative structure. Their active participation in community activities related to health care will enable interpretation of joint practice along with their broader contribution.

The nurse needs space, privacy, furniture, and equipment to enable assessment of, and conferencing with, patients. Other facilitating arrangements may include alternate examining rooms and a health education room.

Components in the practice should be evaluated for enlargement, enhancement, or initiation such as patient education; periodic examinations; visits to homes, nursing homes, or other residential settings; conferences with other care providers in the community, family oriented practice, and satellite possibilities.

Various scheduling patterns evolve in accord with individual and practice factors. The nurse may perform the initial assessment and triage of patients, provide ongoing supervision of patients within mutually developed protocols, and develop a specific caseload. Some practitioners prefer alternation of visits between the physician and nurse with consultation as needed. The nurse may share on-call responsibilities.

Patient choice is preserved.

Maintaining continuity and rapport are important.

Joint practice should provide something more, not less.

What about patient charges?

Patient charges are determined by the providers involved. In some settings there is a uniform charge no matter who provides the service. The fee schedule for a joint practice should be arrived at jointly.

Third party payment also enters into the consideration of patient charges. Some third party payers directly reimburse the services of nurse practitioners.

Health education costs must be included in reimbursement plans.

How is the nurse compensated?

Each practitioner should receive remuneration commensurate with qualifications and proficiency.[1]

Some nurses receive a salary; others are part of the corporate structure. The contribution of the nurse should be reflected in the productivity of the practice. The compensation of the nurse should be individually negotiated and reflect the responsibility assumed.

What about staff privileges at hospitals and other institutions?

Institutional acceptance and implementation of joint practice is important and worth the effort.

The statutes and joint practice statements authorize joint practice, but specific delineation of privileges is left to the hospital or other facility. Privileges should be collaboratively determined and granted by nursing and medical staff. It is the spirit of these privileges that the nurse will work with, not in place of, the physician.

What other measures are helpful in interpreting joint practice?

Explanation of the purpose and methods of joint practice to patients, their families, other physicians and nurses, office and administrative personnel, other care providers, pharmacists, and the general public can be helpful.

Demonstrated skill is more convincing than explanation.

Any other suggestions?

Historically, there has been a continual realignment of the functions of the nurse and physician. The rising demand for health services and the increased competence of nurses are hastening this transition. However, external events and statutes facilitate joint practice; they do not impose or guarantee it. Joint practice can be achieved only by the practitioners involved.

Role innovation may be easier where physicians are scarce, but the joint practice model has validity and advantages in most, if not all, settings.

A last suggestion would be to emphasize the importance of remaining open and flexible in order to respond to needs, to make adaptation, and to realize more fully the evolving contributions of the practitioners involved.

REFERENCES

1. State Medical Society of Wisconsin and Wisconsin Nurses Association Statement on Joint Practice, 1974 (see adjacent box).
2. National Joint Practice Commission. *NJPC Statement on Medical and Nurse Practice Acts*, Chicago: The Commission, 1974. ■

GUIDELINES FOR INSTITUTIONAL JOINT PRACTICE PRIVILEGES

Approved by the Council of the State Medical Society of Wisconsin, April 7, 1979

Nurses and physicians in joint practice may apply for joint practice privileges through the Joint Practice Committee of the institution. If a Committee does not exist, it is recommended that one be established.

I. The Joint Practice Committee of the Institution
   A. Composition
      The membership should consist of physicians and nurses. It is desirable that the Committee include nurse and physician members who are in joint practice and that the chair of the Committee be rotated among nurse and physician members.
   B. Functions
      1. Establishment of a procedure for granting or denial of joint practice privileges.
      2. Review of credentials and qualifications of applicants.
      3. Recommend joint practice appointments to the governing body of the institution.
      4. Establishment of an appeal mechanism.
      5. Establishment of criteria for joint practice privileges.
      6. Establishment of policies and procedures for joint patient care.
      7. Establishment of periodic review of the joint practice within the institution.

II. Suggestions for the Application Form
   A. Curriculum vitae including educational preparation, professional experience, references, description of the program of preparation.
   B. Privileges requested.
   C. Identification of the physician(s) and nurse(s) in joint practice and a descriptive statement of the joint practice relationship.

III. Joint Practice Statement and Guidelines*
   These are available from the State Medical Society of Wisconsin, PO Box 1109, Madison, Wisconsin 53701, and the Wisconsin Nurses Association, 206 East Olin Avenue, Madison, Wisconsin 53713.

   Topics covered are:
   A. Definition of Joint Practice
   B. Joint Practice Statement
   C. Local Joint Practice Committees
   D. Credentials
   E. Relationship of Nurse and Physician
   F. Patients
   G. Quality of Patient Care
   H. Protocols
   I. Professional Liability
   J. Legal Base
   K. Organization for Care
   L. Patient Charges
   M. Nurse's Compensation
   N. Staff Privileges
   O. Other Interpretations and Suggestions.

*These appear in this issue preceding this article.

MEDICAL LIABILITY PREVENTION

THE CONTINUING AND RAPID scientific advances coupled with the increased demands and expectations of patients frequently results in an imbalance between the art and science of medicine. A proper blending of the art and science by the practicing physician and his associates contributes much in the way of patient and professional satisfaction. It appears that the professional liability insurance market is less restricted in Wisconsin than it is in several other jurisdictions. Even so, SMS members are required to pay substantial premium rates for this protection which is so essential to the practice of medicine. The following points in this important area are offered to physicians.

I. Keep your expired professional liability policies

Comment: The Statute of Limitations has been revised to allow actions involving adults to be initiated within three years of the occurrence or one year from discovery of the injury but not later than five years from the occurrence. Actions involving minors are bound by this limitation, or age 10 years, whichever is later. Possession of the policy will be invaluable or you may face the defense alone at your own expense.

II. Keep good records and retain them for years

Comment: See Comment to No. I. In any event retain records in *all* cases for a minimum of six (6) years after date of last treatment. As to the special situations presented by minors and the mentally ill or incompetent, see your personal attorney.

III. Advise patients as to risk involved in not only operative procedures, but also as to side effects of drugs prescribed or administered; this is frequently called "Informed Consent"

Comment: The legal test appears to be "What would the average prudent person in the patient's position have decided if informed of the perils?" No longer is the legal test what the *physician* believes the patient or his representative should know about the risks of the patient.

IV. The "Locality Rule" has been abolished in Wisconsin

Comment: The practitioner be he "generalist" or "specialist" is now subject to liability in an action for negligence if he fails to exercise that degree of care and skill which is exercised by the average practitioner in a class to which he belongs, acting in the same or similar circumstances. Geographical area and its attendant lack of facilities are circumstances that can be considered if appropriate.

V. Continued membership in your Society is recognized by the Courts as vital for continuing education

Comment: The Courts state that there is no lack of opportunity to keep abreast of the advances made in the medical profession and cites the AMA JOURNAL as authority. The same reasoning applies to SMS JOURNAL and the Society's continuing education programs.

VI. Refrain from ill-advised remarks; THINK BEFORE YOU SPEAK

Comment: Many of the malpractice cases have their genesis in the unfortunate thoughtless spontaneous statements of a nurse, a technician or a physician. Warn your employees and assistants to be on the alert at *all* times.

VII. Give prompt notice to insurer in the event of an "incident"

Comment: Should there be any occurrence in the patient-physician relationship which might result in either a claim or litigation, give prompt notice to the carrier. Timely notice and prompt investigation are far superior to waiting for a formal summons.

VIII. Provide Continuity of Care

Comment: Once a physician accepts a patient which requires a course of treatment he should pursue the plan of prescribed care. If the physician is to be out of the area for an extended period he should arrange for suitable coverage and so notify the patient. Should the patient fail to complete the prescribed plan of care, the physician should follow-up and; in either event this should be documented in the patient's record.

IX. Be alert to the suit-prone "litigious" patient

Comment: Some patients have a tendency to be hypercritical of physicians who have previously treated them. Others may have unrealistic expectations of good or perfect results of medical care. In such situations, extreme caution should be exercised so as to minimize the probability that you or a physician who has treated the patient previously will become involved in a liability claim or suit.

X. Avoid discussion of your liability insurance

Comment: The knowledge that you carry insurance *may* precipitate a claim should an unanticipated complication arise or if the patient becomes dissatisfied with the results of a course of treatment.

XI. Always exercise discretion in the collection of accounts

Comment: All patient accounts should be reviewed before being turned over to a collection agency, and special consideration should be given to the accounts of patients who have evidenced any degree of dissatisfaction which might become the basis for a counter charge in the form of a suit against the physician. While the physician is entitled to remuneration for professional services rendered, foregoing payment may be less of a loss than being a defendant in a lawsuit.

XII. Avoid direct contact with a plaintiff's attorney

Comment: In the event of a claim or suit and the plaintiff's attorney attempts to contact you, you are well advised to refer him to your own attorney. Any communication you may have with a plaintiff's attorney — no matter how well intentioned — might very well compromise your defense if the case proceeds to litigation.

XIII. You are responsible for the acts of technicians and assistants in your employ

Comment: Be sure that your insurance covers you for any liability arising from their acts or omissions.

XIV. Insure your corporation or partnership

Comment: A patient may sue both a physician and his corporation or partnership so make sure it is properly insured. ■

The physician's role in school physical therapy/occupational therapy

... Horace K Tenney III, MD, Madison, Wisconsin

IN WISCONSIN, physical therapy and occupational therapy have been available to children in school for at least the last 40 years. At first these services were only available at "orthopedic" schools, but now with the advent of the state law—Chapter 115 of the Wisconsin Statutes—and with the added impetus of federal law 94-142 (Education of all Handicapped Act) more school districts are offering these services.

In the early days when most of the children in these schools had residuals of poliomyelitis or similar disabilities, the therapists' duties and lines of responsibility were clear-cut. There was a clean separation between therapy and education. Now, with the dissolution of the concept of orthopedic schools, the changing role of the therapists and the inclusion of disabilities other than orthopedic, this separation is no longer as evident. Added to this, the legislation has defined physical therapy and occupational therapy as services related to special education and has given schools some jurisdictional powers over this provision. No wonder there is some confusion.

To begin with, let me list some knowns:

1. Wisconsin regulations allow physical therapy and occupational therapy to be given only on the written prescription of a licensed physician. This includes evaluations as well as treatment.
2. Therapy is only to be provided to children who have an exceptional educational need (EEN) as determined by the multidisciplinary team (M-team).
3. The school district must obtain updated medical information and prescription at least yearly on every child receiving therapy.
4. Whereas the physician supplies the medical information and prescription, therapy cannot take place unless the school's multidisciplinary evaluation team (known as M-team) recommends it.
5. When a physician prescribes these treatments, he assumes the same responsibilities as he does for any other medical prescription.
6. The therapy must be ordered on the official DPI form, PI-2127, which encourages the physician to prescribe in terms of goals and objectives.

Physical and occupational therapy are extremely valuable entities for assisting children with muscular, neurological, and other disorders to develop to their full potential. This is especially true when the therapy can be started during infancy and the techniques used follow developmental patterns. At this age there will be some overlapping of the therapies as provided by the physical therapist, the occupational therapist, or both. Therapy is also useful for schoolage children but the techniques and emphasis are different. In most of these older children the rapid developmental changes have slowed and the focus now is improving function—such as in children with amputations, skeletal deformities, or progressive conditions such as muscular dystrophy. Also, as the student gets close to "graduation," the occupational therapist and the teacher may work together in developing prevocational skills.

Because infants with conditions lumped together under the popular (although vague) term "developmental disabilities" seem to be helped by early therapy, the public seems to assume that this is equally true of older children with developmental disabilities. The parents of these children are understandably anxious to get all the help they can for their children and are motivated to try all avenues. In their commendable zeal to do whatever they can for the children with educational handicaps, educators also have turned to physical therapy and occupational therapy for help. Likewise physicians, who are not familiar with this type of children, are uncertain of what therapy can and cannot do.

A pattern we see developing is this: During the evaluation of one child for an exceptional education need (EEN) the school district discovers that physical therapy or occupational therapy has been prescribed by a physician. If the school's multidisciplinary team also finds that therapy is needed, by law the school must provide it. The district then may employ a therapist and thereby "offer" this service. Since this service is available, parents and educators can and do find children whom they believe could benefit from it. Therefore, the next step is to secure a prescription from some physician. This can be done several ways but the least desirable is to send the official prescription form to the physician, or to ask the parents to take it to the physician. This puts the doctor in a bind. He may not have seen the child recently and may not know the details of his present functioning. He may not be thoroughly acquainted with the techniques of therapy, and yet he may feel reluctant *not* to prescribe therapy if the school or parent asks. After all, it is a "free" service and it probably won't hurt the child.

Let us examine the last two statements. First as to cost: Wisconsin statutes provide that school districts can be reimbursed for physical therapy and occupational therapy services on a 70-30 basis with the state picking up the larger part. Items included are: salaries

Doctor Tenney is Director of the Bureau for Children with Physical Needs, Division for Handicapped Children, Department of Public Instruction, State of Wisconsin. Copyright 1981 by the State Medical Society of Wisconsin.

of therapists and therapy aides as well as certain items of equipment and the cost of transporting children for therapy (as opposed to transporting for education). Over a five-year period, 1972-1977, the combined state and local cost rose 100% from $769,364 to $1,533,412. The yearly pattern is shown in the following chart:

FUNDS	1972-73	1973-74	1974-75	1975-76	1976-77
State ....$	512,775	551,359	690,334	889,456	1,072,430
Federal CC ... $	165,406	108,375	18,820	19,660	—0—
Local ...$	91,183	163,980	295,512	380,647	460,932
TOTAL .$	769,364	823,714	1,004,666	1,289,763	1,533,412

This cost could continue to climb since there is no ceiling on it. As long as school districts enroll EEN children who have valid prescriptions for therapy, they will continue to provide more therapy.

Which brings me to the second point that therapy will probably do no harm. In most cases this is true since trained and skilled therapists will use judgment in carrying out the prescription. However, the therapist is not responsible for medical conditions which might contraindicate therapy, such as osteogenesis imperfecta or other conditions such as seizures, heat intolerance, or endocrine problems which could modify the way therapy is given. In prescribing therapy for a child, the physician is assuming the same responsibility and liability he/she does when writing a prescription for a drug. The prudent physician, therefore, will assure himself/herself that the therapy prescribed will improve the child's functioning and that it will do no harm.

The way we would like to see it happening is this: children with handicaps are under the continuous supervision of a physician or multidisciplinary clinic group and are seen at least yearly. If the doctor finds that the child has some disability that requires the expertise of a therapist to allow the child to obtain an education, he enters the prescriptive data on the official form and sends it, along with a summary of his physical findings, to the school district (naturally after securing the parents written permission). The school then convenes an M-team and decides, on the basis of his report and other reports concerning the functioning of this child, whether the child has an exceptional educational need and plans accordingly.

Section 11.19 of the rules adopted for the implementation of Chapter 115 says that—"the physical (occupational) therapist shall have adequate medical information and medical prescription from a licensed physician on the *appropriate division form* ***before*** a child is enrolled in the program."

The official division form is a one-sheet form entitled:

"WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION—OCCUPATIONAL AND PHYSICAL THERAPY PHYSICIAN PRESCRIPTION" and numbered PI-2127.

As long as these rules are in effect, therapy evaluations and/or treatment should not be given unless this form is completed and signed by the physician. This does seem overly rigid but we hope that by requiring this form we can avoid inappropriate use of therapy.

Some physicians prefer to put their therapy directions in a letter which is acceptable as long as the information covers all the points asked for on the PI-2127. It is not necessary for the physician to copy the prescription on to the PI-2127 form, but it is necessary for the physician to sign and date the form and attach the letter. If there is doubt about the completeness of information contained in a letter, the PI-2127 form should be completed.

Since each child who receives physical therapy or occupational therapy requires an individual prescription, it follows that the therapy is to be administered on an individual basis and not in groups. Therapists then do not work with groups of children except occasionally at meal time when the therapists may be involved in facilitating this activity for several children.

The system of individualized therapy will hold for many of the children. However, we know that within the heterogeneity of children with exceptional educational needs, there are also some who show delayed development, awkwardness, clumsiness, perceptual motor difficulties, and the like but who do not have any specific musculoskeletal or neurological abnormalities. We feel it is inappropriate for this group to be receiving formal therapy; rather the program established in the child individual educational program (IEP) should take these deficiencies into account with specific classroom and physical education activities. Even though this group of children would not be receiving individual therapy, a PT/OT could assist the teachers, special education and physical education, in establishing group activities which would accomplish the more educational goals of improved fine or gross motor coordination, etc. A prescription would still be required for the therapists to evaluate the child and set up a program under his/her supervision.

To get the maximum benefit, therapy must extend beyond the activities occurring during the one-half hour or so that the therapist is working on the child. The principles involved should be carried on at other times during the day, both at school and at home. Families should be involved but this needs careful evaluation lest a tenuous social situation be made worse by requiring the wrong amount or type of family involvement.

Public Law 94-142 and its Wisconsin counterpart, Chapter 115, in mandating the education of all children with handicaps, have made it possible for schools to deliver physical and occupational therapy services traditionally thought of as medical services. This is new territory for some districts and they need help from physicians. If there are problems concerning therapy, a call should be made to the district administrator or special education director to discuss them, or a visit to the school might be helpful to see what is offered in terms of special education, adaptive physical education, and therapy. ■

RESPONSIBILITIES AND REQUIREMENTS

Physicians and schools working together

THE FEDERAL AND state legislation passed in the last few years concerning the education of handicapped children has benefited many of our patients and has required joint efforts on the part of physicians and educators. Some of these joint activities have had a positive ambience whereas others, because of different philosophies or because of interpretation of rules, have not been as positive. Certainly, for the good of the child we want to foster mutual cooperation and understanding. There are a few specific points about doctors and schools working together that need emphasis.

① The state law requires that "a parent, physician, nurse, etc. . . .who has reasonable cause to believe that a child brought to him/her for service has exceptional needs *shall* report the name of this child and any other information required to the school board for the district."

According to this statute then, physicians are required to refer children to the school district if they believe the child may need special arrangements in school. This allows the school to begin educating the child at an early age if that is indicated, or at least plan for a later enrollment. The law does not require the physician to obtain permission from the parents before this referral, but naturally the physician would want to discuss this with them and point out the advantages.

② Just as physicians do not appreciate educators making medical decisions ("this child needs an EEG, a CAT scan, and Ritalin®5 mg tid"), so educators do not appreciate physicians making educational decisions ("put him in a self-contained LD classroom and speech therapy three times a week"). The two professionals must work together, each contributing their expertise.

The physician often has known the family and the child for many years and has information that may help the educator as they plan the child's program. This type of information, as well as the specifics of the child's disability and medical needs, should be communicated to the school. It is the educators task, on the basis of the medical information and the results of their educational assessment, to determine what school placement and curriculum is best for the child. This information is contained in the child's individualized educational program (IEP) which the school must develop on all children in special education. If the child has a physical problem which requires some special care or treatment, this also is built into the IEP.

Present regulations state that "related services," (*ie,* physical therapy, occupational therapy, health services, psychological services, etc) must be supplied by the school at no cost to the parents *if* the child has an exceptional educational need (EEN) and *if* the related service is required for the child to receive his/her special education. If these conditions are not met, the school does not have to supply these services free. It is the school that decides if a child needs special education and if such service is related to that, but hopefully they would ask the physician for input when the child has a medical problem.

③ Enthusiastic advocacy can cause problems. Certainly, physicians feel a responsibility to be an advocate for their patients and families—that is part of good medical practice. On the other hand, we know that some parents make demands that are impossible or inappropriate. The physicians can do a great service to the patient, the school and the community by sifting out the appropriate items from those that are not appropriate and helping the school supply them. —**Horace K Tenney III, MD,** Director, Bureau for Children with Physical Needs, Division for Handicapped Children, Department of Public Instruction, State of Wisconsin, Madison.

PESTICIDE POISONING TREATMENT MANUAL AVAILABLE. The SMS Committee on Environmental and Occupational Health informs physicians that a pesticide medical treatment manual is available to physicians at no charge from the US Environmental Protection Agency. The 75-page manual, "Recognition and Management of Pesticide Poisonings," devotes a separate chapter to each major chemical classification of pesticides detailing: 1) names of commonly used pesticides belonging to the group; 2) toxicology; 3) frequent signs and symptoms of overexposure, and 4) recommended treatment. To obtain a free copy, physicians must make their request on their professional stationery to: Chief, Pesticide Branch, US Environmental Protection Agency, 230 South Dearborn Street, Chicago, Illinois 60604. ■

Impaired Physician Program

AN IMPAIRED PHYSICIAN Program has been actively supported and sponsored by the State Medical Society of Wisconsin since early 1977. This function has been assigned to the Society's Commission on Mediation and Peer Review for implementation and ongoing review.

The State Medical Society's Board of Directors recognizes its responsibility to colleagues and continues to encourage development of a dynamic program for *all* Wisconsin physicians including those who are not members of the Society.

Many physicians have benefited through the years of confrontation, helpful intervention, and periodic follow-up. Many programs have been developed to increase the "awareness factor" for the membership as well as the public.

In 1979 the Board of Directors adopted a patient brochure for use in physicians' offices relative to complaints about physicians. The Society took a positive stand at that time and encouraged physicians to distribute these brochures to their patients. The brochures received broad acceptance by the public; they are still available to physicians.

Recently the Board of Directors adopted a new protocol procedure for conducting the Impaired Physician Program. It clearly describes each step of the process of handling a physician impairment problem with full recognition of the due process concept. Briefly, any responsible person can inform the Impaired Physician Program committee of a concern by calling the State Medical Society in Madison: (608) 257-6781 or (800) 362-9080 in Wisconsin. Staff assigned to receive this information will consult with the Commission chairman for early action on the case. However, before action is taken on any case the complaint is evaluated for accuracy. Once it is determined that a potential problem exists, a confronter team is selected to meet with the involved physician. From that point a process evolves which hopefully will assist the physician to recognize the impairment and accept a treatment plan, leading to a recovery phase that returns the physician to a successful practice.

The State Medical Society of Wisconsin and the State Medical Examining Board are working together in a *Statewide Impaired Physician Program—not* to exercise the disciplinary arm of the State of Wisconsin but to establish and develop a Coordinating Council on Physician Impairment between the two bodies. The Coordinating Council's goals are to establish policies and guidelines, coordinate the work of the Society and the Examining Board, promote educational programs, and provide direction to the State Medical Society's Impaired Physician Program.

Uniform Anatomical Gift Act

WISCONSIN, along with some 40 other states, has adopted the Uniform Anatomical Gift Act, a law under which a donor may leave all or any part of his/her body for research or transplantation. With the continuing publicity given to transplant technology, physicians are being queried about the law and how their patients can make anatomical gifts. To assist physicians in providing the necessary information to patients, the University of Wisconsin-Madison Anatomy Department and the Medical College of Wisconsin Department of Anatomy have provided the State Medical Society with the following policy statements in the acceptance of bodies:

University of Wisconsin-Madison Anatomy Department

1. We only accept donated bodies of donors who have forms on file with us at the time of death. (A potential donor's signature on a driver's license is not sufficient. A signed release must be on file by the Anatomy Department.)
2. We reject bodies which we cannot use. Accident victims, severely jaundiced bodies, autopsied bodies, bodies from which organs have been removed for transplant (corneas excepted), bodies discovered too late following death (time varies with the season and temperature), and obese bodies are examples of those which we cannot use.
3. We are no longer receiving bodies from the northern two tiers of counties (Pierce, Dunn, Rusk, Price, Oneida, Forest, Marinette, Door, and all counties north of these).
4. Each potential donor should write for forms and instructions to: Anatomy Department, Bardeen Medical Laboratories, 1215 Linden Drive, University of Wisconsin-Madison, Madison, Wisconsin 53706 (phone 608/262-2888).
5. We make the removals and do our own embalming. There is no expense for the family unless they have a memorial service. Ashes will be returned upon request.

Medical College of Wisconsin, Department of Anatomy

THE MCW ACCEPTS bodies on a donation basis only. These bodies are then used for the purposes of teaching normal Gross Anatomy, medical research, or other scientific educational programs. If a person decides to become a donor, all he/she needs to do is fill out standard Release of Claim form provided by the Department. (This must be done even though the donor may have signed his Driver's License.) Next of kin must also consent to this and sign the form *before* the form is returned to the Department. One copy

should be retained by the donor for his/her files. A wallet-size donor card accompanies the Release of Claim form. The donor can fill this out and carry it with him/her at all times.

Transportation. When death occurs, the hospital, nursing home, or the available responsible person should contact the Department of Anatomy immediately and transportation arrangements made. If death occurs in the Milwaukee area, there is no charge for transportation of the body to the Medical College. However, when death occurs outside the MCW area, there will be a transportation cost to be borne by the donor's estate or his next of kin. If death occurs outside of Wisconsin, it is, perhaps, better to make arrangements with the nearest medical college or university.

Need for alternate plans. The Medical College of Wisconsin does have the right to choose not to accept the donation of a body at the time of death even though donation forms were on file with the MCW. The MCW feels that this is necessary since it must have a use for the body that is consistent with the wishes of the donor. Refusal is sometimes necessary for various reasons, including the following: (1) The body is severely damaged, as from a car accident or fire; (2) An autopsy had been performed on the body; (3) The person is obese; (4) The person is jaundiced; (5) The person has had surgery 30 days prior to death; and (6) Death was due to infectious disease. Therefore, an alternate plan should be arranged in the event that the MCW cannot accept the donation.

Organ donations. The MCW requires that body donors have all major organs left intact. The only exception are the eyes, which may be donated to an Eye Bank (see details below). Therefore, if a person decides to donate his/her body to the Medical College, the person would not be able to donate organs such as the heart or kidney elsewhere for transplants. A person must decide on one type of donation or the other. In general, if the donor is of a young age or otherwise suitable for organ transplant, the MCW would encourage interested donors to use this form of donation since organs suitable for transplants are relatively rare and an immense social service.

The disposition of the remains is by cremation. The ashes are not returned, but are buried properly by the Medical College.

Further information may be obtained by contacting the Medical College of Wisconsin, Department of Anatomy, 8701 Watertown Plank Road, Wauwatosa, Wis 53226. (Mailing address: PO Box 26509, Milwaukee, Wis 53226. Phone 414/257-8261).

Uniform Organ Donor Cards and Decals. These are available from the National Kidney Foundation of Wisconsin, Inc, PO Box 350, Madison, Wis 53701 (phone 608/221-0021), or 7332 West State St, Wauwatosa, Wis 53213 (phone 414/453-2830).

Donation of eyes. Inquiries may be directed to the Milwaukee Eye Bank, 8700 West Wisconsin Ave, Milwaukee, Wis 53226 (phone 414/257-5543), or to The Eye Bank, E5/410 Clinical Science Center, University of Wisconsin-Madison, Center for Health Sciences, 600 Highland Ave, Madison, Wis 53792 (phone 608/263-6223). ■

Can You Practice Without a License?

THE PRACTICE OF medicine and surgery within this state requires a license. Even physicians just finishing their military service, or moving to Wisconsin from another state, *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to disciplinary action as well as criminal penalties.

Temporary licenses may be granted under special circumstances by the State Medical Examining Board. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practive in this state. ■

"Living will" on use of measures to sustain life

Many people express their desire that no "heroic" measures be used to sustain their physical functions if this would result in their being totally incapacitated, comatose, or otherwise severely impaired. Various forms of a "living will," purporting to direct the scope of care to be given or withheld in such situations have been prepared and are in circulation.

It is unlikely that any of these documents can adequately address the complex medical judgments in a particular case but they do offer some guidance on the attitude of a patient who may no longer be able to speak for himself. It remains for serious and considered ethical and professional evaluation to see how and if the expressed attitude can be reflected in the management of the patient. ■

Some considerations in the closing of a physician's practice

While there are no formally slated rules for closing a medical practice, there are several important items which should be considered and planned in advance. The list given below is not complete but the State Medical Society of Wisconsin believes it will be helpful.

1. Notification of patients

Patients should be given adequate notice, a minimum of three months is suggested, in writing that you plan to close your office and on what date so that they will have sufficient time to obtain another physician. It is also suggested that, in the letter of notice to the patients, you enclose a form for the patient to sign authorizing the release of records should they wish to request that a copy of their records be sent to the new physician of their choice. A list of all patients notified should be retained in your files.

You can save postage, in the case of current patients, by inserting the letter with a monthly statement or billing; letters to other patients will have to be mailed separately.

You also may wish to place an announcement in one or more local newspapers.

2. Retention of medical records

(a) Medical records, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others, should not be destroyed until the statute of limitations has expired with regard to each patient. This is because the physician's record and liability insurance policies could be your chief source of defense in a future law suit.

The Statute of Limitations has been revised to allow actions involving adults to be initiated within three years of the occurrence or one year from discovery of the injury but not later than five years from the occurrence. Actions involving minors are bound by this limitation, or age 10 years, whichever is later. Possession of the policy will be invaluable or you may face the defense alone at your own expense.

(b) The patient has a general right to know what is in his medical records and thus you should make it known where such records can be obtained. Such records generally should not be given to the patient, but should be forwarded to another physician of the patient's choice with the consent and at the request of the patient, in writing.

(c) The Wisconsin Statutes relating to the examination or inspection of medical records on patient authorization read:

"**804.10 (4).** Upon receipt of written authorization and consent signed by a person who has been the subject of medical care or treatment, or in case of death of such person, signed by the personal representative or by the beneficiary of an insurance policy on the person's life, the physician or other person having custody of any medical or hospital records or reports concerning such care or treatment, shall forthwith permit the person designated in such authorization to inspect and copy such records and reports. Any person having custody of such records and reports who unreasonably refuses to comply with such authorization shall be liable to the party seeking the records or reports for the reasonable and necessary costs of enforcing the party's right to discover."

3. Disposal of drug stocks

The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

"The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, Post Office Box 28083, Central Station, Washington, D.C. 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration, 517 East Wisconsin Avenue, Room 228A, Milwaukee, Wisconsin 53202; (414) 224-3395.

Instructions on the disposal of non-narcotic drugs in the possession of the physician may be obtained from the Wisconsin Pharmacy Examining Board, 1400 East Washington Avenue, Madison, Wisconsin 53702.

4. Sale of medical practice

(a) If you are selling your practice, you should make certain that the buyer is a physician licensed, or eligible to be licensed, in Wisconsin. This information can be obtained from the State Medical Society or the Wisconsin Department of Regulation and Licensing.

(b) Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician.

5. Keeping your license in force

You may wish to keep your license in force and register each year in the event that you wish to do some consultation work or are called upon to perform some act of medical practice in an emergency. If you elect to keep your license in force, you will be required to continue to meet the continuing medical education requirements. This requirement calls for 30 hours of Category I credit as defined in the Physician's Recognition Award of the American Medical Association, to be accumulated every two years. The Medical Examining Board requires this regardless of extent or nature of practice; there are no exceptions due to age or retirement.

6. Malpractice insurance

Your policy should be examined to determine whether it is written on a CLAIMS INCURRED or a CLAIMS MADE basis. Consult your insurance agent. If the policy is written on a CLAIMS MADE basis, only those claims made while the policy is in force will be covered and you should either continue your coverage or purchase coverage extension to protect you until all statutes of limitation have run.

7. Accounts receivable

Not all of your patients will have paid their bills by the time your practice is closed. It will be necessary to have someone available to accept, record, and deposit payments received after the official closing of your practice. You may wish, after a suitable waiting period of three or four months, to turn those accounts still unpaid over to a reputable collection agency.

8. Continuation of SMS membership

We hope that you will continue to be active in the Society. This can be done by notifying your County Society, in writing, that you are closing your practice but wish to remain active in Society affairs. The County Society will notify you of its dues, if any, for inactive physicians. There are no dues for continuation of SMS or AMA membership in such cases.

9. Income taxes

Copies of your income tax returns and all supporting documentation, including ledgers and accounting records, should be preserved until the Internal Revenue Service can no longer assess additional tax. For returns filed on time and containing all correct and pertinent data, this is usually three years; for returns where gross income has been understated by 20 percent or more, it is six years; for fraudulent returns or where no return has been filed there is no time limit.

10. Payroll taxes

Final returns and payments of all Federal and state withholding and Social Security taxes must be made after the last employee has been terminated and the last payroll paid.

Finally, it is recommended that you work closely with your attorney or business manager particularly on the tax aspects of closing your practice. ■

MEDIC ALERT
FOUNDATION INTERNATIONAL

The Medic Alert emblem is designed to alert emergency personnel to hidden medical conditions. On the back of the emblem is the member's hidden medical condition along with an ID number and 24-hour emergency telephone number which can be utilized to retrieve the computerized emergency medical data within seconds.

Information that is stored can include physician's telephone number, type of insurance policy, next-of-kin, blood type, medication name and dosage.

The Medic Alert Foundation estimated that one out of five Americans has a hidden medical condition, ranging from serious medication allergies to heart problems and diabetes.

In a recent twelve-month period, the service which is subscribed to by over 1.3 million people was directly credited with saving over 2,000 lives.

Free information can be obtained from Medic Alert, Turlock, California 95380. ■

Problems of a Physician's Widow/er

FOLLOWING THE LOSS of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow/er in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow/er. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow/er will be faced with many decisions involving the settlement of the business affairs relating to the late husband's or wife's practice. It is of extreme importance that she/he act upon the advice of an attorney. When practical it is recommended that the physician acquaint his/her spouse with his/her legal and other advisors and some of his/her business affairs. This will provide an established working business relationship between the spouse and the advisors for that eventuality when she/he is called upon to act. Some of the chief problem areas the widow/er will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow/er also will be presented with the problem of what to do with the physician's narcotics. The Regional Administrator of the Drug Enforcement Administration, Chicago, Illinois, has jurisdiction over the State of Wisconsin with regard to disposal of unused controlled substances. The following procedure has been approved as a guide to physicians:

"The physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, P.O. Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Forms and additional information may be obtained from the Milwaukee District Office: Drug Enforcement Administration, 517 East Wisconsin Ave., Room 228A, Milwaukee, Wisconsin 53202; (414) 224-3395.

It is important that a widow/er, other members of the family, and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his/her death may be obtained from the Wisconsin Pharmacy Examining Board, 1400 E Washington Ave, Madison, Wis 53702.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should not be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow/er's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow/er can expect that the deceased physician's patient will seek care elsewhere unless he/she had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his/her patient. In such event, it is wise to insist upon a written request from the patient and his/her new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow/er should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should not be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow/er's legal and other advisors can best inform her/him how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. The widow/er should carefully follow her/his attorney's advice before bringing suit, since a patient can

counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow/er or the heirs to enforce collection by suit within such period. She/he should also seek legal and accounting advice on how long to retain the financial records of her/his late spouse. It is quite possible that his/her estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

A widow/er should consult her/his attorney as to whether the estate needs to arrange a malpractice policy buy-out with the deceased physician's carrier so as to protect the estate assets and the widow/er's share of such assets. Some physicians will have attempted to do this during lifetime and if they did so this will be evident from study of the policy, its endorsements and correspondence. If there is uncertainty in the matter, the attorney should contact the insurance carrier and seek its cooperation in ascertaining the facts. The reason for this is that a suit can be maintained against the estate and heirs of a deceased physician who is alleged to have committed one or more acts of professional negligence with resultant injury to a patient.

The State Medical Society office is always available for consultation with a widow/er, the family, or the estate attorney.■

AUTOPSY

Question: Whose consent is required to permit a physician to conduct an autopsy?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin. If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Section 979.125, Wisconsin Statutes, requires autopsies for infant death in which "sudden infant death syndrome" is suspected, unless the parents specifically object.

CHECKLIST FOR COST CONTAINMENT

Adopted by the State Medical Society of Wisconsin, March 28, 1981

I. Encourage physicians to:

A. Be cost conscious
B. Learn consultant fees
C. Include recent laboratory and x-ray results with referral letters
D. Avoid unnecessary referrals
E. Utilize "one day" care units when possible
F. Consider "morning of surgery" admissions
G. Be selective in use of expensive critical care units
H. Shorten postoperative hospital stays
I. Encourage early evaluation for transfer to extended care facility
J. Critically examine prescribing habits
K. Order only necessary laboratory tests
L. Periodically review hospital bills to learn costs of laboratory, radiology and ancillary services
M. Seek alternatives to hospitalization
N. Discourage "routine" annual physical examinations
O. Discourage "executive physicals"
P. Combine camp, school and athletic examinations

II. Encourage hospitals to:

A. Form cost containment committees
B. Instruct patients on appropriate use of the emergency room
C. Avoid excessive use of laboratory and radiology services in the emergency room
D. Be fully functional on weekends and holidays
E. Post up-to-date patient bills
F. Share purchasing services

III. Encourage patients to:

A. Be aware of health care costs
B. Practice good health habits
C. Evaluate the alleged merits of health foods, vitamins, minerals, etc.
D. "Self treat" minor illnesses and injuries
E. Discuss prescription costs with family pharmacist
F. Use over-the-counter and generic medication when possible
G. Learn about cost savings available in health insurance plans with deductibles and co-insurance■

4 DOZEN REASONS WHY YOU SHOULD STAY IN ORGANIZED MEDICINE

1. Low cost insurance programs such as—hospital-medical-surgical, life, disability, office protection, overhead expense.
2. SMS endorsed collection service.
3. Practice management and financial planning workshops.
4. Discounts on auto rental and leasing programs.
5. Regional continuing medical education conferences.
6. SMS Annual Meeting—offering top-notch scientific and socio-economic programs.
7. Protection of physician-patient interests in relation to Medicare, Medicaid, and other government programs.
8. Medical-legal information system.
9. Legislative liaison on up to 200 health-related bills each session.
10. Involvement in the political process through local Physicians Alliance committees.
11. Assistance on individual physician problems with the state's Medicaid program.
12. Continuous monitoring of the activities of the third-party health insurance carriers.
13. A cost containment effort to give doctors a voice in plans to contain health care costs.
14. Mediation and peer review system to handle patient grievances and assure quality medical care.
15. Physician placement service.
16. The *Medigram* newsletter.
17. A scientific journal: *Wisconsin Medical Journal.*
18. Tour programs at competitive prices.
19. Physicians Alliance field consultants to help organize local political activity.
20. Physician referral service.
21. Negotiations with DHSS regarding physician reimbursement under Medicaid programs.
22. Toll-free member hotline to SMS Headquarters: 800-362-9080.
23. Statewide impaired physician program.
24. Comprehensive research reports on such issues as physician distribution, the Wisconsin public health system, and medical liability.
25. Monitoring of state/federal health planning laws.
26. Input into the Wisconsin State Health Plan.
27. Representing the physician's perspective in the Wisconsin certificate-of-need and decertification programs.
28. The Wisconsin Physician's Planning Network—your voice in health planning.
29. AMA/Wisconsin Jail Health Care Program.
30. Office furniture and book discount purchase plans.
31. Fort Crawford Medical Museum at Prairie du Chien.
32. Financial assistance for students in medical and allied health careers.
33. Charitable assistance to physicians and their families when personal hardship strikes.
34. Funding for scientific and socio-economic research projects.
35. Consumer Health Education Programs to promote a healthier Wisconsin citizenry.
36. Continual liaison with state media personnel to promote medicine's views.
37. A weekly health column currently carried in 90-plus Wisconsin newspapers.
38. Timely public service announcements.
39. Sponsorship of an annual Work Week of Health Program for high school students and health educators.
40. Liaison with Medical Examining Board.
41. Scientific speakers bureau.
42. Patient brochures for the doctor's office on a variety of health education topics.
43. Monitoring and comment on H-24, H-32 codes.
44. Accreditation program for hospitals and specialty societies to insure quality continuing medical education programming.
45. Participation in the rate setting process for WHCLIP and Patient Compensation Fund to assure equitable rates.
46. Consultation services on medical liability matters.
47. A strong commission/committee structure studying a variety of issues.
48. One-day conferences on socio-economic issues. ■

EMPLOYEES ALLOWED TO INSPECT RECORDS UNDER NEW LAW

PHYSICIANS AS WELL as other employers in the state should note the new personnel records inspection law which became effective May 21, 1980. The law gives the employee the right to inspect any employer-maintained personnel records used in hiring, promoting, transfering, giving raises, or terminating that employee as well as certain medical records. The employer is required to grant the employee at least two requests to view records per calendar year, each within seven days of the request, and at a location convenient to the employee during working hours, or other agreeable arrangement. Employers may require that request in writing.

An employee involved in a current grievance against the employer may designate in writing a representative, such as a union agent, to inspect the personnel records. Upon agreement of the employer and employee, any errors or differences of opinion may be noted in the record. If an agreement cannot be reached, the employee may add a written statement, to become part of the permanent file, expressing his/her opinion.

The employee may also inspect any of his/her medical records that are in the employer's file. If the employer feels these medical records would be detrimental to the employee, the employer may release them to the employee's physician or the employee's immediate family.

The employer may withhold some information under the law. Among the exceptions are: any records relating to possible criminal offenses, letters of reference, test documents (the employee may see the test scores), information about a third person, records relating to a pending legal claim between employer and employee, or material used by the employer for staff management planning. For complete details refer to Section 103.13, Wisconsin Statutes.

The AMA House of Delegates approved the *Guidelines for Prescribers of Controlled Substances* at its Interim Meeting in December 1979 after the Board of Trustees recommended endorsement. The Drug Enforcement Agency (DEA) and its Practitioners' Working Committee, of which the AMA is a member, developed these suggested principles for good prescribing practices to "provide a common-sense approach to encourage voluntary compliance by the prescribing professions." Other members of the Committee are the American Dental Association, American Nurses Association, American Osteopathic Association, American Podiatry Association, American Veterinary Medical Association, and the National Institute on Drug Abuse. The AMA Board of Trustees has described the guidelines as "intended to remind practitioners of the potential of controlled substances for drug abuse and dependence, without being restrictive in any sense of the physician's prerogative to prescribe as he sees fit in the best interests of his patients."

Guidelines for prescribers of controlled substances

A Joint Statement of the Drug Enforcement Administration and the DEA/Practitioners Working Committee

THE FOLLOWING embodies the collective thinking of members of the DEA/Practitioners Working Committee. First formed in 1974, this Committee has provided a forum for DEA officials and association executives and practitioners to meet voluntarily to discuss items, issues, and subjects of mutual interest, areas of practical concern, and generally maintain an open and responsive attitude among the various members. Having no intrinsic authority, and seeking none, the DEA/Practitioners Working Committee believes it has played a significant role in promoting the generally harmonious relationships which exist between its national organizations and their respective members. It is against this background of shared experience and knowledge that participants in the work of this Committee offer these "Guidelines for Prescribers of Controlled Substances" to members of the professions throughout the country.

Purpose

The purpose of this joint statement and the presentation of guidelines is to provide and establish acceptable professional responses to the demands of the Controlled Substances Act. The guidelines provide a common sense approach to encourage voluntary compliance by the prescribing professions.

General Statement

The principles expressed in these guidelines constitute neither a pronouncement of law nor a code of ethics, and are not intended to in any way supersede or be in conflict with statutes or ethical concepts governing the conduct of the various practitioners in their respective practices or in their respective professional organizations. Accountability is the responsibility of each discipline.

Application of State and Federal Law

Separate laws relating to the distribution of controlled substances have been enacted in most states. In many cases state law is much more stringent than Federal law and will not allow certain practices which may be authorized under Federal law. The guidelines are an example of good practices which should be encouraged under both Federal and state laws and regulations. Close cooperation and understanding between law enforcement and medicine will ensure that legitimate drugs remain in legitimate channels.

Communication

Recognizing that members of each profession have special competencies and knowledge concerning drugs and related therapeutic agents, a free exchange of information on these matters is encouraged among the professions at all levels.

General Guidelines

- Controlled substances have legitimate clinical usefulness and the prescriber should not hesitate to consider prescribing them when they are indicated for the comfort and well being of patients.
- Prescribing controlled substances for legitimate medical uses requires special caution because of their potential for abuse and dependence.
- Exercise good judgment in administering and prescribing controlled substances so that diversion to illicit use is avoided and the development of drug dependence is minimized or prevented.
- Guard against contributing to drug abuse through injudicious prescription writing practices, or by acquiescence to unwarranted demands of some patients.
- Each prescriber is asked to examine his/her individual prescribing practices to ensure that all prescription orders for controlled substances are written with caution.
- Make specific effort to ensure that multiple prescription orders are not being obtained by the patient from different prescribers.

Guidelines—Prescription Orders

The prescriber is granted through legal authority the right to prescribe medications that are necessary for the proper treatment of his/her patients. Prescribing is governed by laws and regulations which set minimum standards and requirements. These guidelines, tempered with good moral and ethical considerations, give guidance to going beyond the minimum requirements.

- The prescription order must be signed by the prescriber when it is written. The prescriber's name, address, and DEA registration number and full name and address of the patient must be given when prescribing controlled substances.

continued on next page

- The written prescription order should be precise and distinctly legible to enhance exact and effective communications between prescriber and dispenser.
- The prescription order should indicate whether or not it may be renewed and, if so, the number of times or the duration such renewal is authorized.
- Prescription orders for drugs in Schedules III, IV, and V may be issued either orally or in writing and may be renewed if so authorized on the prescription order. However, the prescription order may only be renewed up to five times within six months after the date of issue.
- A written prescription order is required for drugs in Schedule II. The renewing of Schedule II prescription orders is prohibited. Only in an emergency situation may oral orders for Schedule II drugs be accepted by a dispenser.
- Controlled substances which are prescribed without indication for renewal cannot be renewed without authorization by the prescriber.
- Prescribe no greater quantity of a controlled substance than is needed until the next check-up.
- Try to make prescription orders alteration-proof.
- When prescribing a controlled substance, write out the actual amount in addition to giving an Arabic number or Roman numeral in order to discourage alterations in written prescription orders.
- Prescribers are encouraged to consider placing a number of check-off boxes on their prescription blanks which show amounts within which the prescribed amount falls, *i.e.*, 1-25, 26-50, 51-100, over 100.
- Use separate prescription blank for each controlled substance prescribed.
- The use of prescription blanks which are preprinted with the name of a proprietary preparation should be discouraged
- When institutional prescription blanks are used, the prescriber should print his/her name, address, and DEA registration number on such blanks.
- Institutions should discourage the use of institutional prescription blanks for prescribing controlled substances. The prescriber should use his/her own prescription blanks in such instances.

Duty to Inform

The prescriber has the responsibility to inform patients of the effects of the prescribed drugs consistent with good medical practice and professional judgment. The patient has a corresponding duty to comply with the prescriber's directions for use of the prescribed medication.

Each of the professional organizations and the Drug Enforcement Administration has a responsibility to educate and inform the public on proper handling and use of controlled substances. The professions represented on the DEA/ Practitioners Working Committee recognize that they have responsibilities to themselves, beyond legal minimum restraints. ■

NARCOTICS

Annual Registration

A physician who desires to dispense, administer, or prescribe any controlled drug substance is required to have a Drug Enforcement Administration number (DEA no.). The initial registration application may be obtained from the Chicago Regional Office. The Regional Office of DEA in Chicago has informed the State Medical Society that DEA Headquarters will then annually mail a renewal application to each physician once initially registered.

Change of Residence

If you move, or change your place or places of business, you must notify the Drug Enforcement Administration, Registration Branch, PO Box 28083, Central Station, Washington, DC, 20005.

In Case of Death

The Regional Director, Drug Enforcement Administration, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's DEA number (Controlled Substances Registration Certificate), unused Government order forms and controlled drugs should be disposed of as soon as possible. The registration certificate and unused Government order forms (DEA-222 c) should be returned to the Drug Enforcement Administration, Registration Branch, P O Box 28083, Central Station, Washington, DC 20005. The controlled drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Administrator, Drug Enforcement Administration, 219 South Dearborn, Suite 1800, Chicago, Illinois 60604, after the drugs have been inventoried on Form DEA-41, which can be obtained from any DEA office. One copy of the Form-41 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to DEA."

Preprinted Prescription Blanks

The Justice Department, Drug Enforcement Administration, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

STATEMENT

Prescribing habits with benzodiazepine class of drugs

Prepared by the Committee on Alcoholism and Other Drug Abuse of the State Medical Society of Wisconsin and approved by the Society Council, May 17, 1980

The benzodiazepines are among the most widely prescribed drugs in the United States. Their safety and efficacy have been heretofore unparalleled among the sedative hypnotic drugs. However, new evidence is appearing with increasing frequency in the literature that long-term benzodiazepine use (four to six months) has the potential to cause physical and psychological dependence. A withdrawal syndrome, which may feature anorexia, insomnia, agitation, hypertension, and tachycardia, has been documented in numerous patients—which syndrome is not to be confused with the condition for which the drug was originally prescribed. In addition, seizures and hallucinations have been reported upon abrupt cessation of even therapeutic doses of benzodiazepines.

There is evidence in one study, that benzodiazepines are prescribed for women twice as often as men. We urge physicians to rethink their experiences with benzodiazepines in light of the new evidence that associates long-term use with major withdrawal sequelae.

REFERENCES*

1. Winokur A, Rickels K, Greenblatt DJ, Snyder PJ, Schatz MD: Withdrawal reaction from long-term, low-dosage administration of diazepam. *Arch Gen Psychiatry,* Vol. 37, January 1980.
2. de la Fuente JR, Rosenbaum AH, Martin HR, Noven RG: Lorazepam-related withdrawal seizures. *Mayo Clin Proceedings,* March 1980, Vol. 55, No. 3.
3. Dyksen MW, Chan CH: Diazepam withdrawal psychosis: A case report. *Am J Psychiatry* 134:537, 1977.
4. Preskorn SH, Denner LJ: Benzodiazepines and withdrawal psychosis. *JAMA* 237:36-38, 1977.
5. Pharmaceutical Data Services, Prescription Card System, Phoenix, Arizona, 1979. Unpublished data.

*The references are to be considered a part of the statement.

PRESCRIBING OF THERAPIES

SOUND MEDICAL PRACTICE dictates that the prescription of psychiatric, psychological, social work, physical therapy, occupational therapy, speech and other types of therapy be provided only when medically necessary, and then followed by the physician as with any other prescribed treatment. The State Medical Society urges that all physicians carefully follow these guidelines:

1. Psychological, social work and other therapies *must first be prescribed by a physician,* only after adequate evaluation of the patient by the physician with documented findings of medical necessity for treatment, specific plans for such treatment and duration of treatment are clearly stated. The treatment must also be monitored by the physician.
2. Physicians *need not* and, in fact, must not sign any forms from nursing homes or other institutions unless the services are medically necessary.
3. Do not prescribe on the basis of solicited prescriptions.
4. As with any prescription, the progress of therapy should be reviewed with the patient and/or the therapist at regular intervals and the prescription renewed as indicated.

Following such sound medical practices will not only conserve Medicaid dollars, but will protect the reputation of physicians and insure delivery of ethical, high quality service when it is medically necessary. The Society, in cooperation with county medical societies and specialty societies, is prepared to investigate the involvement of physicians in any alleged abuses. Any cases of actual abuse that are discovered will be referred to the appropriate ethics committee of the societies. Improper conduct by members or nonmembers, if substantiated, will be followed by disciplinary action including, if need be, removal from membership or referral to the Medical Examining Board.

PHYSICIANS *NOT* EXEMPT FROM JURY DUTY. Physicians are no longer automatically exempt from serving as a juror. However, there are some qualifying circumstances under which a physician might be excused in the discretion of a judge for hardship or extreme inconvenience. Physicians interested in further details may contact the SMS Physicians Alliance Division.

ADOPTION

STATE LAW REGULATES the adoption of children and licenses the agencies involved in adoptive placements to the problems and abuses inherent in "black market" adoptions.

Licensed private child welfare agencies and special governmental agencies are authorized to take custody of children, become their guardians, provide care and maintenance for them, place them in foster homes (which must also be licensed) and initiate necessary steps leading to adoption.

No one else may perform these functions in the adoptive process and the physician must be careful to refer patients either having a child for adoption or seeking to adopt to the appropriate agencies. (See box on this page.)

Placement of a child for adoption or receipt of such a placement may subject those involved, including an intermediary, to criminal prosecution. Failure of the parties to follow legally established procedures for adoption is grounds for a court to refuse to grant the adoption.

Similar precautions are taken with interstate adoption situations and consent must be obtained from the Department of Health and Social Services before any child is brought into Wisconsin or sent from this state for adoption. ■

THE ABUSED CHILD LAW

Abuse of children by parents and others can be found at all economic, educational, and social levels. The cumulative effect of repeated beatings or other forms of severe abuse, which may include physical crippling, brain damage or even death, must be prevented.

The Abused Child Law makes reporting of suspected cases of child abuse mandatory by physicians and others dealing with children. They are required to report cases of suspected child abuse. The law further provides that the reports be made to the city police departments, sheriffs, and county child welfare agencies. Civil as well as criminal immunity from suit is granted where a report is made in good faith. Child abuse has been made a Class E felony (punishable by a fine up to $10,000 and imprisonment up to two years).

The actions of the Legislature have immeasurably increased the probabilities that perpetrators of abuse will be identified and will receive rehabilitative help while the abused child will be extended protection from further abuse.

Relevant portions of the law, quoted from the Wisconsin Statutes, appeared in the June 1979 *Blue Book* issue. ■

GOOD SAMARITAN LAW

The Legislature has broadened the immunity provided by the Wisconsin Good Samaritan Law to cover any person rendering aid at the scene of an emergency. First enacted to protect physicians, these laws are common throughout the United States. They are designed to encourage prompt care for persons who are injured or become ill away from normal locations where treatment is given.

The scene of an emergency does not include a hospital or physician's office. Persons employed and trained to render emergency care, acting for compensation and within the scope of their employment are not protected under the law. ■

WISCONSIN ADOPTION AGENCIES

Licensed Voluntary Agencies

Catholic Social Services—Diocese of Green Bay, 131 South Madison St, PO Box 38, Green Bay 54305

Catholic Charities, Inc,—Diocese of LaCrosse, 128 South 6th St, PO Box 266, LaCrosse 54601

Catholic Social Services—Diocese of Madison, 25 South Hancock St, Madison 53703

Catholic Social Services of the Archdiocese of Milwaukee, Inc, 207 East Michigan St, Milwaukee 53202

Children's Service Society of Wisconsin, 610 North Jackson St, Milwaukee 53202

Lutheran Children's Friend Society, 8138 Harwood Ave, PO Box 13367, Wauwatosa 53213

Lutheran Social Services of Wisconsin and Upper Michigan, 3200 West Highland Blvd, Milwaukee 54308

Seven Sorrows of Our Sorrowful Mother Infants' Home, Rt #1, Box 905, Necedah 54646

Wisconsin Lutheran Child and Family Service, 6800 North 76th St, Milwaukee 53233

Public Agencies

Division of Community Services (Regional Offices) (See page 101 for list of Regional Offices.)

Milwaukee County Department of Social Services, Child Welfare Division, 1220 West Vliet St, Milwaukee 53205

Maternity Homes

Lutheran Maternity Home, 1910 South Avenue, LaCrosse 54601

Rosalie Manor, 19305 West North Ave, Brookfield 53005

• • •

Agencies licensed to make adoptive home studies and to contract with other agencies to make placements but not licensed to accept guardianship.

The Human Element, Inc, 2701 North 56th St, Milwaukee 53210

Soul, Ltd, 6185 Rosewood Dr, Appleton 54911

FDA's toll-free number

The Food and Drug Administration has a toll-free number for physicians to call to report problems with drugs, medical devices, and *in vitro* diagnostic products. The purpose is to help the FDA determine when a product poses a significant potential health hazard. Problems with which the FDA is concerned are hazardous or potentially hazardous products, mislabeling, incomplete or confusing instructions, erroneous information, nonsterile products, packaging errors, and other quality control errors. The number to call is: **1-800-638-6725.**

How to get health-related information in Wisconsin

THE WISCONSIN HEALTH Sciences Library Network, a network of libraries that blanket the state, stands ready to put Wisconsin health-care practitioners in touch with information in libraries throughout the country.

Any practitioner needing such information should first contact the library in his or her institution. If the person is an independent practitioner or the institution has no library, another local hospital or clinic should be contacted. Many such libraries will now serve people who are not among their primary clientele. A great number of these libraries are now organized into resource-sharing consortia and can get a needed item quickly even if they do not have it in their own collection. The libraries are also eligible to forward requests to the two Wisconsin resource libraries—in Madison (the UW Middleton Health Sciences Library) and in Milwaukee the Todd Wehr Library (Medical College of Wisconsin). The local libraries are likely to have the tools to identify which other library has the needed information.

If no local library can be found to provide these services, inquiries can be sent directly to the resource libraries at the addresses given below. Any requests that can't be filled at the state level are eligible for referral to resource libraries in the Midwest Health Science Library Network, which encompasses a six-state area, to the National Library of Medicine; and, if necessary, to the British Lending Library.

In addition to providing lending and photocopying services, the two resource libraries and many of the local libraries provide reference service. Computer searches, including MEDLINE, can now be done at the resource libraries and at Columbia, Lutheran, St Joseph's, St Luke's, St Mary's, St Michael's, Mt Sinai, St Francis hospitals and Good Samaritan Medical Center, Lutheran Campus in Milwaukee; Milwaukee County Medical Complex; Trinity Hosital, Cudahy; VA Hospital, Wood; St Elizabeth's Hospital, Appleton; Luther Hospital, Eau Claire; LaCrosse Lutheran Hospital; Marshfield Clinic, Marshfield; Bellin Memorial Hospital, Green Bay; Waukesha Memorial Hospital, Waukesha; the Howard Young Medical Center, Woodruff; Methodist and St Marys hospitals in Madison. If your local library cannot provide computer searches, it can forward any request to the most appropriate library in the network.

In most cases, the only charges will be for computer searches and for photocopies.

University of Wisconsin
Middleton Health Sciences Library
1305 Linden Drive
Madison, Wisconsin 53706
800-362-3020
Ext 2-2376

Medical College of Wisconsin
Todd Wehr Library
Box 26509
Milwaukee, Wisconsin 53226
414/257-8326 ■

THE WISCONSIN POISON CONTROL PROGRAM NETWORK

It is a health service that provides standardized poison management information and treatment to both medical professionals and the general public through a network of regional and satellite centers.

Each center is staffed by specially trained poison information professionals available to answer telephone inquiries 24 hours a day, seven days a week. Telecopying equipment enables the staff to make immediate contact with national headquarters in Pittsburgh when additional information or research is needed on difficult cases of ingestion.

The centers:

- recommend treatment procedures to physicians and to the public in poison emergencies.
- maintain a record of calls received, treatment advised or given and disposition of the case.
- report certain poison incidents to the Division of Health.

The two regional centers are:

Milwaukee Poison Center
Milwaukee Children's Hospital
1700 W Wisconsin Avenue
Milwaukee, WI 53233
Tel 414/931-4114

Poison Center — Madison Area
University Hospitals
600 Highland Avenue
Madison, WI 53792
Tel 608/262-3702

The three satellite centers are:

Eau Claire Poison Center
Luther Hospital
310 Chestnut Street
Eau Claire, WI 54701
Tel 715/835-1515

Green Bay Poison Center
St Vincent Hospital
P O Box 1221
Green Bay, WI 54305
Tel 414/432-8621

LaCrosse Poison Center
St Francis Hospital
709 South 10th Street
LaCrosse, WI 54601
Tel 608/784-3971

In addition, other small poison control centers in many other hospitals may have direct contact with a regional or satellite center to receive assistance as a "member center" of the network.

This information provided by the

WISCONSIN DEPARTMENT OF HEALTH
AND SOCIAL SERVICES
DIVISION OF HEALTH

PO Box 309 Madison, Wis 53701

ABORTION

Wisconsin, like several other states, has a law denying subsidies from any public source for non-therapeutic abortions except in cases in which conception results from sexual assault or incest. Laws of this nature have been subject to challenge in the courts in other states. The validity of Wisconsin's law, if challenged, cannot be predicted.

In Wisconsin spousal consent for abortions is not required by law. Medical Assistance (Title XIX) does fund abortions.

Physicians and hospitals are granted immunity from civil liability for refusal to perform abortions. In the case of the physician this immunity is conditioned on the refusal having been based on religious or moral precepts. No hospital, school, or employer may discriminate against a physician in regard to employment, tenure, or staff privileges or status for refusal to perform abortions if this is based on religious or moral precepts.

STATE MEDICAL SOCIETY OF WISCONSIN

Accreditation Program

for Continuing Medical Education

Information is available in printed form from either Bill Wendle, Scientific Affairs Coordinator, or Arlene Meyer, Administrative Assistant, Continuing Medical Education, State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701; or telephone toll-free in Wisconsin 1-800-362-9080 (Madison area: 257-6781).

Representatives of the American Medical Association took the initiative to bring about the unification of a body responsible for accreditation of continuing medical education. This effort resulted in the adoption by the AMA House of Delegates at its Interim Meeting in December 1980 of the report of the Board of Trustees recommending the creation of the Accreditation Council for Continuing Medical Education (ACCME) and the bylaws for this new organization (which became operational January 1, 1981) and assumed the responsibility for national accreditation of organizations, institutions, and agencies offering continuing medical education. The state medical associations will retain the responsibility for accreditation of intrastate continuing medical education in accordance with the agreements reached in the creation of ACCME as stated in its bylaws.

The State Medical Society of Wisconsin's accreditation program functions under the authority of the AMA's newly created Accreditation Council for Continuing Medical Education (ACCME). Representatives from state medical societies, national medical specialty societies, AMA Section on Medical Schools and Resident Physician's Section, National Medical Association, American Hospital Association, Association for Hospital Medical Education, Federation of State Medical Boards, and medical specialty boards comprise the ACCME.

CATEGORY 1—CME activities with accredited sponsorship . . . Education activities that are a part of a planned program of continuing medical education and sponsored by an accredited organization . . . (including)

- Grand rounds
- Teaching rounds
- Departmental scientific meetings
- Seminars and Workshops
- Clinical Traineeships
- Mini-residencies
- Scientific sessions of medical specialty societies
- Visiting lecture programs
- Continuing medical education courses
- Audiovisual materials (under specified conditions).

CATEGORY 2—CME activities with non-accredited sponsorship (same activities as in Category 1, offered by a non-accredited medical organization. No formal approval is necessary for an organization to offer Category 2 credit).

CATEGORY 3—Medical teaching.

CATEGORY 4—Papers, publications, books, presentations, and exhibits.

CATEGORY 5—Non-supervised individual . . . activities (includes) self-learning, consultations, patient care review, self-assessment, specialty board preparation.

CATEGORY 6—Other meritorious learning experiences.

continued on opposite page

HELPING THE RETARDED, DEVELOPMENTALLY DISABLED PERSON

The family physician is very often the first person a family turns to when they suspect their child may be mentally retarded.

A resource the physician may wish to use in counseling the family is the local Association for Retarded Citizens. And a call to the local Unified Board or Developmental Disabilities Board will identify the resources that are available to a family in their county.

There should be local resources, psychological services, OT, etc available to complement the physician's examination. Also there are several clinics within the state that provide specialized evaluations for the persons who are mentally retarded and for persons with other developmental disabilities.

- **Child Development Center**
  Dr June Dobbs, Director, Child Development Center, Milwaukee Children's Hospital, 1700 West Wisconsin Ave, Milwaukee, Wisconsin 53201; (414) 931-4069

- **University Hospitals**
  Dr Charles Schoenwetter, H6 4th Floor, 600 Highland Ave, Madison, Wisconsin 53792; (608) 263-6421

- **Waisman Center on Mental Retardation**
  Linne Cain, Intake Coordinator, 1500 Highland Ave, Madison, Wisconsin 53706; (608) 263-5777

- **Comprehensive Evaluation Clinic for Multiple-Handicapped Children**
  Ms Marilyn Gratto, Miller-Dwan Hospital, 502 East 2nd Street, Duluth, Minnesota 55805; (218) 727-8762

Further information may be obtained from Merlen Kurth, Executive Director, Wisconsin Association for Retarded Citizens, Inc, 2700 Laura Lane, Middleton, Wis 53562; (608) 831-3444.

CME Accreditation Program/*continued*

WISCONSIN INSTITUTIONS AND ORGANIZATIONS ACCREDITED *by SMSW and ACCME for continuing medical education programming at April 15, 1981*

Appleton Memorial & St Elizabeth Hospitals, Appleton
Bellin Memorial Hospital, Green Bay
Beloit Memorial Hospital, Beloit
Berlin Memorial Hospital, Berlin
Columbia Hospital, Milwaukee
Community Memorial Hospital, Menomonee Falls
Deaconess Hospital, Milwaukee
Ft Atkinson Memorial Hospital, Ft Atkinson
Gundersen Medical Foundation Ltd & La Crosse Lutheran Hospital, La Crosse
Hartford Memorial Hospital, Hartford
Howard Young Medical Center, Woodruff
Kenosha Memorial Hospital, Kenosha
Lakeland Hospital, Elkhorn
Langlade County Memorial Hospital, Antigo
Luther Hospital, Eau Claire
Lutheran Hospital, Milwaukee
Madison General Hospital, Madison
Memorial Hospital of Iowa County, Dodgeville
Memorial Hospital of Oconomowoc, Oconomowoc
Methodist Hospital, Madison
Mount Sinai Medical Center, Milwaukee
Osseo Area Municipal Hospital, Osseo
Reedsburg Memorial Hospital, Reedsburg
Sacred Heart Hospital, Eau Claire
Sauk Prairie Memorial Hospital, Prairie du Sac
Shawano Community Hospital, Shawano
Sheboygan Memorial & St Nicholas Hospitals, Sheboygan
St Agnes Hospital, Fond du Lac
St Catherine's Hospital, Kenosha
St Clare Hospital, Baraboo
St Clare Hospital, Monroe
St Francis Hospital, La Crosse
St Joseph's Hospital, Chippewa Falls
St Joseph's Hospital & Marshfield Clinic, Marshfield
St Joseph's Hospital, Milwaukee
St Joseph's Community Hospital, West Bend
St Luke's Hospital, Milwaukee
St Marys Hospital Medical Center, Madison
St Mary's Hospital, Milwaukee
St Mary's Hospital, Rhinelander
St Michael Hospital, Milwaukee
St Michael's Hospital, Stevens Point
St Vincent Hospital, Green Bay
Theda Clark Memorial Hospital, Neenah
Trinity Memorial Hospital, Cudahy
Veterans Administration Medical Center, Tomah
Watertown Memorial Hospital, Watertown
Waukesha Memorial Hospital, Waukesha
Wausau Medical Center, Wausau
West Allis Memorial Hospital, West Allis
Winnebago Mental Health Institute, Winnebago

Cancer Committee, St Francis Hospital, Milwaukee
American Cancer Society, Wisconsin Affiliate
American Heart Association, Wisconsin Affiliate
Fox Valley Academy of Medicine
Madison Academy of Internal Medicine
Milwaukee Academy of Medicine
The Milwaukee Academy of Surgery
The Milwaukee Gynecological Society
Milwaukee Ophthalmological Society
Milwaukee Orthopaedic Society
The Racine Academy of Medicine
State Medical Society's Section on Ophthalmology
Wisconsin Academy of Family Physicians
Wisconsin Allergy Society
Wisconsin Association for Perinatal Care
Wisconsin Clinical Cancer Center
Wisconsin Dermatological Society
Wisconsin Neurological Society
Wisconsin Orthopaedic Society
Wisconsin Otolaryngological Society
Wisconsin Psychiatric Association
Wisconsin Surgical Society
Wisconsin Urological Society
Wisconsin Society of Obstetrics & Gynecology
Wisconsin Society of Pathologists
Wisconsin Society of Plastic Surgeons
The Wisconsin Society of Radiation Oncologists

Marinette-Florence County Medical Society

AMA Accredited
Dept CME, Medical College of Wisconsin
Dept CME, UW Center for Health Sciences
Interstate Postgraduate Medical Association
The State Medical Society of Wisconsin
Wisconsin Society of Anesthesiologists

Charter Law of Medical Societies

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, bylaws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 Service insurance corporations for health care. The state medical society or, in a manner approved by the state society, a county society, may establish in one or more counties of this state a service insurance corporation for health care under ch. 613.

NOTE ON ss. 148.03, 447.13, 449.15 and 450.13; Chapter 613 provides in general terms for the creation, governance and regulation of service insurance corporations for any kind of health care, as well as for other types of services. All that is needed in each authorizing chapter for professional societies is a brief section giving the appropriate professional society the power to organize a ch. 613 corporation. Section 148.03 creates that section for health care.

One basic restriction results from the repeal of the old enabling sections: none of the professional societies will be able to organize a service insurance plan within its own corporate structure. It is a mistake to permit such a mixing of professional and insurance activities within the same corporation. The society can, of course, control the service insurance corporation it creates under ch. 613, but the service insurance corporation will be legally separate. This will lead to more effective (and appropriate) control by the insurance commissioner, who should neither be empowered nor compelled, as arguably he was under the old statutes, to have any concern about the purely professional activities of the societies, because of the impossibility of disentangling the insurance and professional activities carried on by a single corporation. ■

DECLARATION OF GENEVA

Adopted by the General Assembly of the World Medical Association at Geneva, Switzerland, September, 1948

AT THE TIME OF BEING ADMITTED AS MEMBER OF THE MEDICAL PROFESSION:

I solemnly pledge myself to consecrate my life to the service of humanity.

I will give to my teachers the respect and gratitude which is their due.

I will practice my profession with conscience and dignity.

The health of my patient will be my first consideration.

I will respect the secrets which are confided in me.

I will maintain by all means in my power, the honor and the noble traditions of the medical profession.

My colleagues will be my brothers.

I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.

I will maintain the utmost respect for human life, from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.

I make these promises solemnly, freely, and upon my honor.

1841—The Society created by territorial legislation

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art . . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin . . ." Drs. Bushnell B. Cary, M.C. Darling, Lucius L. Barber, Oliver E. Strong, Edward McSherry, E.W. Wolcott, J.C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B.O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society. ■

CONSTITUTION AND BYLAWS
of the State Medical Society of Wisconsin

CONSTITUTION

ARTICLE I
Name of the Association

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II
Purpose

The purpose of the Society is to bring together the physicians of the state of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws. As used in the Constitution or Bylaws, "physician" means a doctor of medicine or a doctor of osteopathy licensed in Wisconsin.

ARTICLE III
Component Societies

Component societies shall consist of those county medical societies chartered by the House of Delegates of this Society.

ARTICLE IV
Composition of the Association

This Society shall consist of members who shall be the members of and certified by the component county medical societies; and whose dues and assessments for the current year have been received by the Society secretary in accordance with the schedule provided in the Bylaws.

ARTICLE V
House of Delegates

The House of Delegates shall be the legislative body of the Society, and shall consist of:

(1) delegates elected by the component county medical societies,
(2) one delegate representing each specialty section of the Society organized under the Bylaws,
(3) a speaker,
(4) a vice speaker.

The officers of the Society enumerated in Article IX of this Constitution, directors, and past presidents of the Society shall be ex officio members, but without the right to vote, except that if they have been duly seated as delegates, they shall have the right to vote.

The speaker and vice speaker shall be elected by and from the House of Delegates for two-year terms, and shall be limited to three consecutive full terms in their respective offices. While holding these offices, they shall be members of the House at large and shall not represent any component county society or specialty section.

ARTICLE VI
Board of Directors

The Board of Directors, hereinafter referred to as "Board," shall have full authority and power of the House of Delegates between sessions of the House. It shall consist of the directors, immediate past president, president, president-elect, speaker and vice speaker of the House of Delegates. The secretary and the treasurer shall be ex officio members of the Board, but without the right to vote. A majority of its voting members shall constitute a quorum.

Directors shall be elected from eight geographic districts whose boundaries shall be determined by the House of Delegates. There shall be elected one director from each district, except that in any district with 200 or more regular and special members, there shall be elected one additional director for each additional 200 members or majority fraction thereof. As nearly as possible, one-third of the members of the Board shall be elected each year.

Each director shall be nominated and elected only by the elected delegates of the county medical society or societies from the district in which the director's principal place of practice is located. Such election shall be subject to the approval and confirmation of the House of Delegates.

The terms of the directors shall be for three years. No individual shall be permitted to serve more than three consecutive three-year terms as director, and no more than a total of six terms of service as director shall be permitted.

ARTICLE VII
Specialty Sections

The House of Delegates shall provide for a division of the Society into specialty sections.

ARTICLE VIII
Meetings

Section 1. The Society shall hold an Annual Meeting, at which time the House of Delegates shall meet to conduct its business. The Annual Meeting may also include scientific sessions as determined by the Board.

Sec. 2. The place for holding each Annual Meeting shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Board. The time for holding each Annual Meeting shall be approved by the Board.

Sec. 3. Special meetings of the House of Delegates shall be called by the speaker on written request of twenty delegates representing at least 10% of the component county medical societies, or on request of a majority of the Board. When a special meeting is called, the speaker shall set the time and place. The secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the date of the special meeting. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall consider no business except that for which it is called.

ARTICLE IX
Officers

Officers of this Society shall be a president, a president-elect, a secretary, and a treasurer. The president-elect and treasurer shall be elected annually by the House of Delegates. The secretary shall be elected annually by the Board. The president-elect shall automatically succeed to the office of president at the conclusion of the term as president-elect.

Adopted by the House of Delegates March 27-28, 1981.

The treasurer shall be limited to nine consecutive terms.

No person shall hold more than one of the following offices concurrently: president, president-elect, secretary, treasurer, speaker, vice speaker, director. Incumbents shall serve until their successors are elected and installed.

ARTICLE X
Funds and Expenses

Funds may be raised by annual dues or by assessment on the members, or in any other manner approved by the House of Delegates. The House may establish regular and special classifications of membership. Dues, if any, shall be applied equitably to all members in each class.

All resolutions adopted by the House of Delegates providing for appropriations shall be referred to the Board for implementation. All expenditures approved by the Board shall be included in the annual budget.

ARTICLE XI
Referendum

The House of Delegates may, by a two-thirds vote of those registered at that session, submit any question to the membership of the Society for its vote, except amendments to the Constitution. Such amendments are governed by Article XIII. The House shall determine prior to submission whether a referendum shall be advisory or binding, and so advise the membership at the time of submission. A majority vote of all the members of the Society shall determine the question on a binding referendum.

ARTICLE XII
Seal

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII
Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any Annual Meeting, provided that such amendment shall have been introduced in the form of a constitutional amendment in open session at the previous Annual Meeting, and that it shall have been published at least once during the year in the Journal of this Society, or sent to each member of the Society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER 1
Membership

Section 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of the county society, shall be *prima facie* evidence of membership and of the right to benefits.

Sec. 2. No person whose name has been dropped from the roll of members of a component society or this Society shall be entitled to any of the rights or benefits of this Society, except that such rights and benefits shall continue during the period of an appeal by such person to the Board of Directors.

Sec. 3. Every physician who holds a license to practice medicine and surgery in Wisconsin shall be eligible to apply for membership. Each county society shall be the judge of the initial and continuing qualifications of its members, as well as the appropriate membership classification, subject to review and final decision by the Board of this Society. Members will conduct themselves in a manner which is not in conflict with the purposes for which the Society is organized and is operating.

Sec. 4. By provision of its constitution or bylaws, a county society may require that an applicant shall have practiced within its jurisdiction for a period of one year as a condition for election to membership; or that an applicant may first be elected to membership for a term of one year only, then resubmit to election by vote of the county society without limitations as to term.

Sec. 5. A member of a component society whose license has been revoked, suspended, nonrenewed, or voluntarily surrendered, shall be immediately and automatically suspended from membership as of the date of revocation, suspension, nonrenewal, or voluntary surrender, pending definitive action by the Board.

Sec. 6. A physician's county society membership must be held in that county in which the physician's principal practice is located. However, a physician living near a county line may hold membership in that county most convenient for attending meetings, with concurrence of the component society in which the principal place of practice is maintained.

Sec. 7. A member whose principal practice is moved from within the territorial limits of a component medical society to the territory of another component of the State Society shall not be eligible to continue membership in the first such society after the expiration of the calendar year in which such move shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society into whose jurisdiction the principal practice has been moved. The member shall be given a written certificate of transfer for transmission to the secretary of the society in the county to which he has moved. Pending acceptance or rejection by the society in the county to which he has moved, such member shall be considered to be in good standing in the first society and in the State Society until the end of the period for which dues have been paid.

Sec. 8. When the principal practice of a member in good standing in a component society is moved outside the borders of this state, active membership in such component society and in the State Society may be continued by fulfilling all requirements of membership except residence pending acceptance as a new or transfer member by the society of the area to which the practice has been transferred. The period of such continuing membership in this state shall cease upon acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which the practice location has been transferred.

Sec. 9. *Membership Classifications.* Members defined in this section, except Affiliates, shall have all the rights and privileges of the Society and shall pay dues and assessments, as indicated, as a requirement of continued membership.

A. *Regular.* Regular members of this Society consist of all the regular members in good standing of the component county societies.

B. *Special.* Included in this classification are the following categories of members who by virtue of their special circumstances are entitled to reduced dues or waiver thereof:

(1) *Part-time practice.* Any physician, regardless of age, who practices 1,000 hours or less during a calendar year, but does not qualify under section 9.B. (5), may upon application, recommendation by the

county medical society, and approval by this Society, be placed in this special category.

(2) *Resident.* Physicians in approved training programs as hospital residents or as research fellows who are licensed to practice medicine and surgery in Wisconsin. Such special membership category can be maintained for a maximum of five (5) consecutive years.

(3) *Temporary Military Service.* Members who are inducted into the United States Military or Public Health Service and serve in such capacity for not more than five (5) years.

(4) *Associate.* Members who suffer a disability preventing them from practicing medicine with resulting serious financial reverses which would make the payment of dues a matter of personal hardship. Such membership shall be on an annual basis, upon recommendation of the county society and approval by the Board of this Society.

(5) *Retired.* Members who have retired completely from the practice of medicine, or who practice 240 hours or less during a calendar year, upon recommendation of the county society and approval by this Society.

(6) *Life.* Those members of the State Medical Society of Wisconsin who have been members of this or other state medical societies for fifty (50) years, or are past presidents of the State Medical Society of Wisconsin. They shall receive a certificate of Life Membership.

(7) *Honorary.* Members who have been elected to a similar classification by their county society because of outstanding contributions to the medical profession, upon approval by the Board of this Society.

(8) *Over Age 70.* Members who are age 70 effective January 1 of the following year.

C. *Affiliate.* Persons who are not otherwise eligible for membership may become affiliated with this Society in one of the following categories. Their dues or assessments, as well as rights and privileges as affiliate members, shall be determined by the Board.

(1) *Candidate.* Upon application, a county medical society or this Society may confer upon any person then attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure the status of Candidate Member.

(2) *Scientific Fellow.* The Board may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy, the status of Scientific Fellow.

(3) *Emeritus.* Retired members who have chosen not to renew their license, at the discretion of the Board.

Sec. 10. *Dues and Assessments.* Members shall pay dues and assessments as follows:

A. *Regular members:* full dues and assessments.

B. *Physicians in part-time practice or over age 70:* one-half of regular member dues and assessments.

C. *Physicians in residency or fellowship training:* one-tenth of regular member dues and assessments.

Dues and assessments for all other categories shall be waived, except as may be determined by the Board for affiliate members.

CHAPTER II
House of Delegates

Section 1. Each component county society shall be entitled to send one delegate and one alternate to the House of Delegates for each forty regular and special members or majority fraction thereof in this Society, provided, however, that each county society shall be entitled to at least one delegate and one alternate from that county society.

For purposes of this section, the number of members as of the close of the calendar year preceding the first session of the House of Delegates at the Annual Meeting shall determine the number of delegates to which a county society shall be entitled.

The secretary of each county society will send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve.

Sec. 2. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

Sec. 3. The speaker shall preside at the meetings of the House of Delegates.

Sec. 4. The vice speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice speaker shall officiate during the unexpired term.

Sec. 5. The speaker shall appoint members of reference committees from among the members of the House of Delegates. These committees shall consider and make recommendations to the House relative to resolutions, reports of officers, reports of commissions and committees, financial and other matters germane to the business of the House. The speaker shall also appoint a credentials committee and such other committees as deemed necessary.

Sec. 6. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Sec. 7. The House of Delegates shall have authority to create committees for special purposes and to appoint members of the Society who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and their members may be present to participate in the debate on their reports.

Sec. 8. It shall receive for appropriate action the annual reports of the treasurer, secretary, and chairman of the Board of Directors.

Sec. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society two months before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Board of Directors or any member thereof, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

Sec. 10. All questions of an ethical nature brought before the House of Delegates shall be referred to the Board of Directors without discussion.

CHAPTER III
Annual Election

Section 1. The House of Delegates, at its first session of the Annual Meeting, shall elect a Committee on Nominations consisting of one (1) delegate for each district, except

that in any district having five hundred (500) or more regular and special members, there shall be elected one (1) additional delegate for each additional five hundred (500) members or majority fraction thereof. One (1) delegate representing the specialty sections shall also be appointed. This committee shall become operative at the close of the final session of that Annual Meeting and shall function until the close of the final session of the following year's Annual Meeting. The incoming committee shall meet with the existent committee but without vote during the overlapping days of the Annual Meeting. Any vacancy occurring in the Committee on Nominations between the date of its formation and the time of its reporting shall be filled by appointment by the director or directors of the district in which the vacancy occurs, provided that if the vacancy occurs in the representation from the specialty sections, such vacancy shall be filled by ballot from among the section delegates.

The Committee on Nominations shall convene at least two (2) months prior to the Annual Meeting of the House of Delegates to prepare a slate of candidates. This meeting, to be held at a time, date and location published to the general membership at least two (2) months before this meeting, shall include an open session of not less than one (1) hour to allow individual nomination of candidates. The Committee shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the positions to be filled.

Sec. 2. The report of the Committee on Nominations and elections shall be the first order of business of the House of Delegates at the third session of the Annual Meeting.

Sec. 3. The House of Delegates shall elect the president-elect, the treasurer, the speaker and vice speaker of the House of Delegates, and the delegates and alternates to the American Medical Association. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by separate ballot for each individual position, and a majority of the votes cast shall be necessary to elect. If no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped, except where there is a tie, and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of the votes cast.

Sec. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

CHAPTER IV
Duties of Officers

Section 1. The president is the chief constitutional officer of the Society. Within the limits of the Constitution, Bylaws, and policies of the House of Delegates and Board of Directors, the president shall have the following responsibilities and commensurate authority:

a. Deliver an annual address to the House;
b. Serve as a member with right to vote on the Board;
c. Preside at meetings of the Executive Committee of the Board;
d. Participate, ex officio and without the right to vote, in sessions of the House;
e. Initiate and propose policies and programs that will further the goals and objectives of the Society for consideration by the House, Board, commissions and committees;
f. Support and articulate policies and programs adopted by the Board and the House;
g. Promote physician interest and active participation in the Society.

Sec. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant, the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect, the Board shall appoint one of its members as acting president until the next meeting of the House of Delegates.

Sec. 3. The treasurer shall be responsible to the Board of Directors, and shall advise and assist it in making decisions on investment policy and financial matters. The duties of the treasurer shall include the following:

a. Be responsible for all funds due the Society, together with bequests and donations;
b. Pay money out of the treasury only on written order of the secretary;
c. Subject the treasurer's accounts to such examination as the House of Delegates may order;
d. Annually report on the financial standing of the Society, including a balance sheet and income and expense report;
e. Give bond in such amount as the Board may provide.

Sec. 4. The secretary is the chief executive officer of the Society charged with the execution of policy as created and defined by the House of Delegates and the Board of Directors. Duties of the secretary shall include being secretary of and responsible to the Board; assisting the officers in making decisions and implementing actions; sharing convictions and arguing their merits as requested. Duties as chief executive officer shall be:

a. Assume the general managerial duties of all Society divisons, activities, and personnel;
b. Be custodian of all records and papers belonging to the Society, except such as properly belong to the treasurer;
c. Keep account of and promptly turn over to the treasurer all funds of the Society which come into the secretary;
d. Maintain current copies of each component county society's constitution and bylaws;
e. Conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointments and duties;
f. With the approval of the Board, employ such assistants as are needed to effectively execute the policies of the Society;
g. Make an annual report to the House of Delegates.

CHAPTER V
Board of Directors

Section 1. The Board of Directors shall be the executive body of the Society. Between meetings of the House of Delegates it shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

Sec. 2. The Board shall meet during the Annual Meeting and at such other times as necessity may require, subject to the call of the chairman or on petition of three directors. It shall hold an annual meeting for purposes of organization and other business.

Sec. 3. The Board shall elect a chairman and a vice chairman from among its voting members. It may create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities. Its chairman shall submit an annual report to the

House of Delegates including all major actions and policy decisions of the preceding year.

Sec. 4. Each director shall be the organizer and mediator for the district. Directors shall visit each county in their district as needed for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep informed of the activities of the component societies in the district. Each director shall arrange for an annual conference or caucus with the societies or their delegates within the district, at which time information shall be disseminated concerning the activities of the State Medical Society and component societies within the district. Each director shall report as necessary to the Board. The necessary traveling expenses incurred by each director in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include the expense of attending the Annual Meeting of the Society.

Sec. 5. The Board of Directors shall be the judicial body of the Society. It may decide any questions of conduct or discipline of members, or any questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. It shall develop and publish procedures for discipline, including denial of initial or continuing membership, for those physicians who fail to provide quality health care, failure to pay dues, loss of license to practice, or other cause. Its decisions in all cases shall be final, including the right to expel a member should a component society fail to do so after being so requested by the Board.

The Board's right to original jurisdiction includes but is not limited to the right to decide cases when:

a. the affected parties reside within the boundaries of a single county medical society and that society does not wish to assume jurisdiction;
b. the affected parties reside in two or more component medical society jurisdictions.

The Board also has within its authority the right to appoint a commission or commissions to which any or all such matters may be referred for investigation, evaluation and decision to acquit, admonish, or otherwise discipline as appropriate. A member may appeal to the Board the decision of such commission or the action of a county society as provided in Chapter X, Section 3. If the recommendation is for suspension or expulsion of a physician from Society membership, final action must be taken by the Board.

Sec. 6. Charters shall be issued to county societies only on approval of the Board, with ratification by the House of Delegates, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Board, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

Sec. 7. In sparsely settled sections, the Board shall have authority to organize the physicians of two or more counties into societies. These societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Sec. 8. The Board shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have the authority to appoint an editor of the Journal and such assistants as it deems necessary.

Sec. 9. The Board shall select a qualified independent accounting firm and receive an annual audit of all accounts of this Society. With the treasurer, it shall supervise the investment of funds. The Board shall adopt an annual budget providing for the necessary expenses of the Society.

Sec. 10. The Board may, by interim appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between Annual Meetings of the House of Delegates. The appointee shall serve until a successor has been elected and has qualified.

When a district initially qualifies for an additional director, such position shall be considered new and not a vacancy to which the Board is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article VI of the Constitution. The initial term shall be so established as to maintain the election of substantially one-third of the directors each year.

Sec. 11. The Board may elect as secretary one who need not be a physician or a member of the Society.

Sec. 12. The formation of salary schedules of all employees of the Society shall be the responsibility of the Board.

Sec. 13. The Board shall provide such facilities for the Society as may be required to properly conduct its business.

CHAPTER VI
Commissions and Committees

Section 1. The Board shall appoint such commissions and committees, either permanent or ad hoc, as it deems necessary to properly conduct the affairs of the Society. Membership on such committees and commissions shall be limited to members of the Society and its Auxiliary. Nonmembers of the Society or its Auxiliary may be appointed as special representatives should their expertise and knowledge be of benefit to the goals of such commissions or committees. Such individuals shall not have the right to vote or hold office.

Each commission and committee shall have the duty of being informed on matters within the area of its special interest. They shall represent the Society's interests by continual contacts with voluntary and governmental agencies having related concerns with the intention of coordinating efforts to serve the health interests of the people of Wisconsin. They shall develop recommendations from their studies and activities for action by the Board or House of Delegates.

Sec. 2. Specialty sections shall be regarded as special committees of the Society from which the Board or any commission or committee may seek advice and assistance on matters of special or general concern to the profession and the health of the people of Wisconsin. The specialty sections will be expected to give special requests prompt consideration and response so as to enable the Society to make maximum use of their resources.

CHAPTER VII
Dues and Assessments

Section 1. The annual dues and assessments of this Society shall be determined by the House of Delegates and shall be levied per capita on the members. Dues and assessments shall be payable as determined by the Board of Directors. Any member whose current year's dues have not been received by the secretary of this Society by May 15 shall be deemed in arrears and his name shall be removed from the membership rolls of his county society and this Society until such time as full dues for the current year have been received.

Sec. 2. The record of payment of dues and assessments on file in the offices of this Society shall be final as to the fact of payment by a member and to the right to participate in the business and proceedings of the Society or the House of

Delegates and to any other benefits and privileges of membership.

CHAPTER VIII

The Board of Directors shall adopt ethical guidelines for the members of this Society.

CHAPTER IX

The current edition of Sturgis Standard Code of Parliamentary Procedure governs this organization in all parliamentary situations that are not provided for in the law or in its charter, constitution, bylaws, or adopted rules.

CHAPTER X
County Societies

Section 1. All present county societies or those that may hereafter be organized in this state shall, upon application to the Board of Directors, receive charters from this Society, provided that their constitutions and bylaws have been submitted to the Board and found in conformity with the Constitution and Bylaws of the State Medical Society. All revisions shall be submitted to the Society, approved by the Board, and filed with the secretary. Where a county society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Board, shall be deemed to apply.

Sec. 2. Only one component medical society shall be chartered in each county.

Sec. 3. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Board of Directors of the State Society. Its decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Board of the State Society for final determination. The mechanisms and procedures which apply to the appeal process shall be those adopted by the Board.

Sec. 4. Each component county society shall elect one or more delegates and may elect an equal number of alternates to substitute for any absent delegates from that component society, for a term of two calendar years, to represent it in the House of Delegates of this Society, in accordance with Chapter II, Section 1, of these Bylaws. The term of office shall begin on January 1 of the year succeeding the election of such delegates and alternates.

Sec. 5. The secretary of each county society shall keep a roster of its members.

CHAPTER XI
Specialty Sections

Section 1. The House of Delegates shall establish specialty sections within the Society. It shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

Sec. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest. Qualifications for membership in any section shall be established by the members of such section, subject to approval of the Board of Directors. Scientific meetings of a section shall be open to all members in good standing of the State Medical Society.

Sec. 3. The officers of each section shall be elected by and from its membership. The terms of such officers shall be for one year, but any officer may be reelected.

Sec. 4. No section shall have the power to bind the State Medical Society by any resolution or other action. No such resolution or action shall be publicized unless it shall first have been approved by the House of Delegates, or by a majority of the Board when the House is not in session. No resolution adopted by any section shall be effective until likewise so approved.

Sec. 5. Each section shall elect a delegate and an alternate to the House of Delegates. The term shall be for two calendar years without limitation on number of terms.

Sec. 6. The specialty sections of the Society shall be considered an integral part of the working committee structure of the Society as outlined in Chapter VI of these Bylaws.

CHAPTER XII
Amendments

These Bylaws may be amended at any Annual Meeting by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day. ■

AMERICAN MEDICAL ASSOCIATION

PRINCIPLES OF MEDICAL ETHICS

PREAMBLE:
The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

WORKER'S COMPENSATION AND THE PHYSICIAN

MOST WISCONSIN PHYSICIANS become involved with treatment of patients covered by Worker's Compensation, which provides payment of compensation for disability, and for medical expenses necessary because of injury or illness arising out of employment.

The State Medical Society's Committee on Environmental and Occupational Health, which maintains liaison with the Worker's Compensation Division, offers the following helpful information:

Filing reports. Filing reports is a direct responsibility of any physician who treats patients under the Worker's Compensation Program. WC-16 Medical Report on Industrial Injury is to be completed on a work-related injury or illness when the disability exceeds three weeks or when any permanent disability results therefrom. WC-16 is available from the insurance carrier or from WC Division. Information reported is used by the WC Division to determine the amount of compensation payable to the disabled worker.

Estimating disability. Learn to estimate disability according to standards set up by the WC Division. Other standards or schedules are fine for physicians' own information, but only the WC Division's standards are authoritative in Wisconsin (see "New Rules Established for Estimating Disabilities in Workmen's Compensation Cases" which appeared in the June 1975 BLUE BOOK, pp 43-45).

Completing reports. Complete report forms carefully and fully. Learn terminology of the statutes concerning compensable employment disability.

Submitting reports. Submit reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. An unexpected misfortune may place the employe in urgent need of compensation.

Payment for reports. Occasionally physicians request reimbursement for preparing and filing reports. The Committee on Environmental and Occupational Health wishes to restate the following principles:

—Simplified reports including initial reports, progress reports, and final reports: No charge.
—WC-16 Report: No charge.
—When a special report, such as the WC-16B, is requested by the WC Division, or the insurance carrier requires an extensive or extra-ordinary report in lieu of a simplified report, a reasonable charge for preparation and filing is appropriate.

Don't be afraid to ask questions. Contact either the State Medical Society or John Byrnes of the Worker's Compensation Division, 201 East Washington Ave, Box 7901, Madison, Wis 53707 (tel 608/266-1340).

BOARD DISTRICTS AND DIRECTORS

District	Director
1—	John P Mullooly, MD, Milwaukee
	Jerome W Fons Jr, MD, Cudahy
	Carl S Eisenberg, MD, Milwaukee
	Wayne H Konetzki, MD, Waukesha
	Wayne J Boulanger, MD, Milwaukee
	Fredrick Wood Jr, MD, Kenosha
	William A Nielsen, MD, West Bend
	Irwin J Bruhn, MD, Walworth
	Thomas A Hofbauer, MD, Menomonee Falls
	William L Treacy, MD, Milwaukee
2—	J D Kabler, MD, Madison
	James J Tydrich, MD, Richland Center
	William P Crowley Jr, MD, Madison
	Allen O Tuftee, MD, Beloit
	Cyril M Hetsko, MD, Madison
3—	Pauline M Jackson, MD, LaCrosse
4—	John J Kief, MD, Rhinelander
	Jung K Park, MD, Wisconsin Rapids
5—	Darold A Treffert, MD, Fond du Lac
	Timothy T Flaherty, MD, Neenah
6—	Roger L von Heimburg, MD, Green Bay
	Irvin L Schroeder, MD, Plymouth
7—	Paul S Haskins, MD, River Falls
8—	Joseph M Jauquet, MD, Ashland

THE SOCIETY'S PLACEMENT SERVICE AIDS PHYSICIANS AND COMMUNITIES

One of the many functions of the State Medical Society of Wisconsin is to assist physicians who are seeking a location to practice in Wisconsin and to assist communities seeking the services of physicians. This activity is called Placement Service.

The Society's Placement Service maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Files are also maintained on communities desiring physicians. Information is exchanged with interested physicians and communities, with the American Medical Association, and with the two Wisconsin medical schools. There is no charge to either physician or community for this service.

A list of openings is sent to all physicians who contact Placement Service indicating that they desire to locate in Wisconsin or desire to relocate within the state. A list of physicians is sent to all communities who request assistance in obtaining a physician. The physicians contact the communities and the communities may contact the physicians. Physicians desiring associates may also request a listing of available physicians.

Experience of Placement Service shows that physicians seek locations on a long-range basis—some are available at once, while others are in residency for two or three years; even medical students have requested location lists. One word of advice: Advise the Society's Placement Service of your needs as soon as possible. Overnight results have occurred, but more time usually means better results.

Physicians and communities may also utilize the "Medical Yellow Pages" section of the *Wisconsin Medical Journal*. This is a classified advertising section which is available to members of the State Medical Society, other physicians, communities, clinics, hospitals and others at reasonable rates.

Physicians who have used the Placement Service have described it as one of the most effective in the United States. *Journal* advertising, too, has proved highly successful.

Inquiries should be addressed to Placement Service, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, tel. 608/257-6781; and/or *Wisconsin Medical Journal,* Box 1109, Madison, Wis. 53701

OFFICERS AND DIRECTORS: 1981-1982

STATE MEDICAL SOCIETY OF WISCONSIN
330 East Lakeside St (PO Box 1109), Madison, Wisconsin 53701
Telephone: 608/257-6781 (toll-free in Wisconsin 1-800-362-9080)

Officers of the Society

President (1981-1982)
Albert J Motzel Jr, MD, 1111 Delafield St, Waukesha 53186

President-elect (1981-1982)
Gerald C Kempthorne, MD, PO Box 466, Spring Green 53588

Secretary/General Manager (1981-1982)
Earl R Thayer, 330 East Lakeside St, Madison 53701

Treasurer (1981-1982)
John J Foley, MD, PO Box 429, Menomonee Falls 53051

Board of Directors

Chairman: *Darold A Treffert, MD*
Vice Chairman: *Timothy T Flaherty, MD*

Directors (by districts*)

FIRST: Kenosha, Milwaukee, Ozaukee, Racine, Walworth, Washington, Waukesha Counties

John P Mullooly, MD (1979-1982): 8430 W Capitol Dr, Milwaukee 53222
***Jerome W Fons Jr, MD* (1979-1982): 3533 E Ramsey Ave, Cudahy 53110
Carl S Eisenberg, MD (1980-1983): 3003 West Good Hope Rd, Milwaukee 53209
Wayne J Boulanger, MD (1981-1984): 2015 E Newport, Milwaukee 53211
Thomas A Hofbauer, MD (1981-1984): PO Box 427, Menomonee Falls 53051
Wayne H Konetzki, MD (1981-1984): 403 N Grand Ave, Waukesha 53186
William A Nielsen, MD (1981-1984): 217 S 17th Ave, West Bend 53095
Irwin J Bruhn, MD (1981-1984): Rt 1, Lakeville Rd, Walworth 53184
Fredrick Wood Jr, MD (1981-1984): 6530 Sheridan Rd, Kenosha 53140
William L Treacy, MD (1981-1984): 10125 W North Ave, Milwaukee 53226

SECOND: Adams, Columbia, Dane, Dodge, Grant, Green, Iowa, Jefferson, Lafayette, Marquette, Richland, Rock, Sauk Counties

J D Kabler, MD (1979-1982): 1552 University Ave, Madison 53706
Cyril M Hetsko, MD (1979-1982): 1313 Fish Hatchery Rd, Madison 53715
§*James J Tydrich, MD* (1979-1982): 1313 W Seminary St, Richland Center 53581

Allen O Tuftee, MD (1979-1982): 1905 Huebbe Parkway, Beloit 53511
William P Crowley Jr, MD (1981-1984): 20 S Park St, Madison 53715

THIRD: Buffalo, Crawford, Jackson, Juneau, La Crosse, Monroe, Trempealeau, Vernon Counties

Pauline M Jackson, MD (1980-1983): 1836 South Ave, La Crosse 54601

FOURTH: Clark, Florence, Forest, Langlade, Lincoln, Marathon, Oneida, Portage, Price, Taylor, Vilas, Wood Counties

John J Kief, MD (1980-1983): 1020 Kabel Ave, Rhinelander 54501
†*Jung K Park, MD* (1980-1982): 410 Dewey St, Wisconsin Rapids 54494

FIFTH: Calumet, Fond du Lac, Green Lake, Outagamie, Waupaca, Waushara, Winnebago Counties

‡*Darold A Treffert, MD* (1979-1982): 459 E First St, Fond du Lac 54935
Timothy T Flaherty, MD (1980-1983): 547 E Wisconsin Ave, Neenah 54956

SIXTH: Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, Sheboygan Counties

Roger L von Heimburg, MD (1980-1983): 900 S Webster, Green Bay 54301
Irvin L Schroeder, MD (1979-1982): 210 Selma St, Plymouth 53073

SEVENTH: Barron, Chippewa, Dunn, Eau Claire, Pepin, Pierce, Polk, Rusk, St Croix, Burnett, Washburn Counties

Paul S Haskins, MD (1980-1983): 409 Spruce St, River Falls 54022

EIGHTH: Ashland, Bayfield, Douglas, Iron, Sawyer Counties

Joseph M Jauquet, MD (1981-1984): 200 7th Ave West, Ashland 54806

* * *

PRESIDENT: *Albert J Motzel Jr, MD* (1981-1982), 1111 Delafield St, Waukesha 53186
PRESIDENT-ELECT: *Gerald C Kempthorne, MD* (1981-1982), PO Box 466, Spring Green 53588
PAST PRESIDENT: *Russell F Lewis, MD* (1981-1982), 1000 N Oak Ave, Marshfield 54449
SPEAKER: *Duane W Taebel, MD* (1981-1983), 1836 South Ave, La Crosse 54601
VICE SPEAKER: *Chesley P Erwin, MD* (1981-1982), 8700 West Wisconsin Ave, Milwaukee 53226

* * *

Ex officio, without vote
Secretary *Thayer,* Treasurer *Foley*

Delegates and Alternate Delegates to the AMA appear on the following page.

*Map indicating location of districts appears on opposite page.
**Elected in 1981 to complete unexpired term of Doctor LaBissoniere
§Elected in 1981 to complete unexpired term of Doctor Kempthorne.
†Elected for a two-year term because the fourth district wished not to have both Board members' terms expiring in the same year.
‡Elected in 1981 to complete unexpired term of Doctor Peters.

NOTE: Officers, directors, delegates, alternate delegates, and members of commissions and committees are elected at the Annual Meeting (March 1981). Dates in parentheses indicate beginning and expiration of term of office. AMA delegates and alternate delegates' terms of office are on a calendar basis, although elected at the Annual Meeting.

Delegates to the American Medical Association

Gerald J Derus, MD (1980-1981), 5001 Monona Dr, Madison 53716
Henry F Twelmeyer, MD (1980-1981), 2500 N Mayfair Rd, Wauwatosa 53226
DeLore Williams, MD (1981-1982), 8501 W Lincoln Ave, West Allis 53227
Patricia J Stuff, MD (1981-1982), PO Box 522, Bonduel 54107
John K Scott, MD (1981-1982), 1 South Park St, Madison 53715

———

[*Henry F Twelmeyer, MD* 1982-1983), 2500 N Mayfair Rd, Wauwatosa 53226)—succeeding himself]
[*Richard W Edwards, MD* (1982-1983)—succeeding Doctor Derus]

Alternate Delegates to the AMA

John D Riesch, MD (1981-1982), PO Box 427, Menomonee Falls 53051
Cornelius A Natoli, MD (1981-1982), 2760 Hagen Rd, La Crosse 54601
Richard W Edwards, MD (1981), 1313 W Seminary St, Richland Center 53581
Warren H Williamson, MD (1980-1981), 500 Walton, Racine 53402
John R McKenzie Jr, MD (1980-1981), 415 S Meadow, Oshkosh 54901

———

[*J D Kabler, MD* (1982-1983), 1552 University Ave, Madison 53706—succeeding Doctor Williamson]
[*Kenneth M Viste Jr, MD* (1982-1983), 631 Hazel St, Oshkosh 54901—succeeding Doctor McKenzie]
[*Walter J Woloschek, MD* (1982), 2500 N Mayfair Rd, Milwaukee 53226—to complete unexpired term of Doctor Edwards]■

SMS AUXILIARY: 1981-82

ELECTED OFFICERS

President: Mrs Donald A Peterson, 1101 Merrill Springs Road, Madison 53705
President-elect: Mrs Leonard Torkelson, 1380 Franklin Street, Baldwin 54002
Vice President: Mrs Robert C Baldwin, 119 Concord Avenue, Watertown 53094
Recording Secretary: Mrs Marshall Cushman, 3831 Lighthouse Drive, Racine 53402
Treasurer: Mrs Charles Yale, 209 Farwell Drive, Madison 53704
Immediate Past President: Mrs Glenn M Seager, Route 1, Box 125, Carla Court, Stoddard 54658

DIRECTORS

East Central: Mrs K Alan Stormo, 270 Sheboygan Street, Fond du Lac 54935
West Central: Mrs Patrick Macken, 1421 Jensen Road, Eau Claire 54701
Northeast: Mrs Gerald Gehl, 210 Elm Street, Neenah 54956
Northwest: Mrs Charles Longstreth, Route 1, Box 163J, Maple Ridge Road, Ashland 54806
Southeast: Mrs A R Pequet, 15635 Kata Drive, Elm Grove 53122
Southwest: Mrs C A Natoli, 2760 Hagen Road, La Crosse 54601

APPOINTED OFFICERS

Parliamentarian: Mrs Robert E Johnston, 3825 Waubenoor Drive, Green Bay 54301
Historian: Mrs Joseph Tobin, 601 Rock Avenue, Eau Claire 54701

EXECUTIVE SECRETARY

Mrs LaVerne Bartel, 330 East Lakeside Street, Madison 53715■

HOUSE OF DELEGATES: See page 44 of February issue.

BOARD OF DIRECTORS COMMITTEES: 1981-82

Executive Committee of the Board

Albert J Motzel Jr, MD, Waukesha—*Chairman*
President of the Society
Gerald C Kempthorne, MD, Spring Green
President-elect of the Society
Russell F Lewis, MD, Marshfield
Immediate Past President of the Society
Darold A Treffert, MD, Fond du Lac
Chairman of the Board
Timothy T Flaherty, MD, Neenah
Vice Chairman of the Board
Duane W Taebel, MD, LaCrosse
Speaker of the House of Delegates
William A Nielsen, MD, West Bend
Chairman, Finance Committee
Roger L von Heimburg, MD, Green Bay
Ex Officio nonvoting members
President and President-elect of SMS Auxiliary

Finance Committee of the Board

William A Nielsen, MD, West Bend, 1984
Chairman
Joseph M Jauquet, MD, Ashland, 1984
Wayne J Boulanger, MD, Milwaukee, 1983
Cyril M Hetsko, MD, Madison, 1982
Jung K Park, MD, Wisconsin Rapids, 1982
Irvin L Schroeder, MD, Plymouth, 1982
John J Foley, MD, Menomonee Falls
Treasurer, ex officio

Auxiliary Advisory Committee

Mrs Donald A Peterson, Madison
President of the Auxiliary
Mrs Leonard Torkelson, Baldwin
President-elect of the Auxiliary
Albert J Motzel Jr, MD, Waukesha
President of the Society
Gerald C Kempthorne, MD, Spring Green
President-elect of the Society
Russell F Lewis, MD, Marshfield
Past President of the Society
Darold A Treffert, MD, Fond du Lac
Chairman of the Board
Timothy T Flaherty, MD, Neenah
Vice Chairman of the Board
Mr Earl R Thayer, Madison
Secretary■

Cost Containment Committee

Established by the Council in 1980

Jeremy R Green MD, Green Bay
Raymond R Johnson MD, Ladysmith
William C Miller, MD, Wausau
George C Owen MD, Milwaukee
Guenther P Pohlmann MD, Milwaukee
John O Simenstad MD, Osceola
James V Seegers MD, Elkhorn
Robert A Starr MD, Viroqua
Joseph L Teresi MD, Brookfield
Fredrick Wood Jr MD, Kenosha
Harry J Zemel MD, Fond du Lac

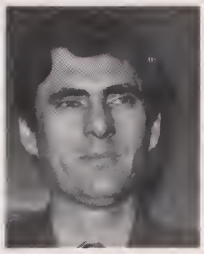
OFFICERS AND DIRECTORS: 1981-1982

STATE MEDICAL SOCIETY OF WISCONSIN

A J Motzel Jr MD
President

G C Kempthorne MD
President-elect

E R Thayer
Secretary

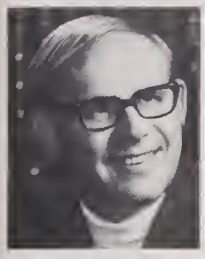


J J Foley MD
Treasurer

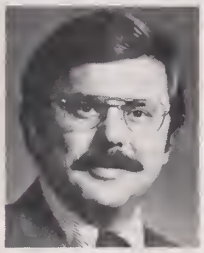
R F Lewis MD
Past President

D W Taebel MD
Speaker

C P Erwin MD
Vice-Speaker



D A Treffert MD
Board Chairman
Director, Dist 5



T T Flaherty MD
Board V-Chairman
Director, Dist 5

W J Boulanger MD
Director, Dist 1

J P Mullooly MD
Director, Dist 1

J W Fons Jr MD
Director, Dist 1

T A Hofbauer MD
Director, Dist 1

C S Eisenberg MD
Director, Dist 1

W H Konetzki MD
Director, Dist 1

W A Nielsen MD
Director, Dist 1

I J Bruhn MD
Director, Dist 1

F Wood Jr MD
Director, Dist 1

W L Treacy MD
Director, Dist 1

W P Crowley Jr MD
Director, Dist 2

A O Tuftee MD
Director, Dist 2

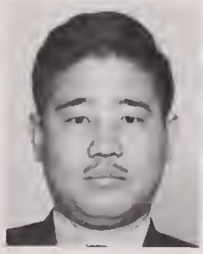
C M Hetsko MD
Director, Dist 2

J D Kabler MD
Director, Dist 2

J J Tydrich MD
Director, Dist 2

P M Jackson MD
Director, Dist 3

J J Kief MD
Director, Dist 4



J K Park MD
Director, Dist 4

R L von Heimburg MD
Director, Dist 6

I L Schroeder MD
Director, Dist 6

P S Haskins MD
Director, Dist 7

J M Jauquet MD
Director, Dist 8

COMMISSIONS AND COMMITTEES: 1981-1982

STATE MEDICAL SOCIETY OF WISCONSIN
330 East Lakeside St (PO Box 1109), Madison, Wisconsin 53701
Telephone: 608/257-6781 (toll-free in Wisconsin 1-800-362-9080)

COMMISSIONS

Continuing Medical Education

This commission shall consist of nine appointed members and the deans of the two medical schools in Wisconsin, with vote. It shall be responsible for all matters relating to the whole continuum of medical education, i.e., medical school and residency training as well as lifetime medical learning (continuing medical education). In addition, it shall be responsible for liaison with the medical schools in Wisconsin, their students, residents, fellows and departments of continuing medical education; liaison with specialty societies in the achievement of these goals; liaison with the Commissions on Peer Review and Health Planning for purposes of implementing continuing medical education programs related to responsibilities and activities of these two commissions; and the scientific program of the Annual Meeting. It shall be responsible for accreditation of continuing medical education in hospitals and other institutions or organizations within the state, but shall not be responsible for accreditation of continuing medical education within the state's medical schools.

C William Freeby, MD, Appleton, 1982
Bradley G Garber, MD, Osseo, 1982
Edwin L Overholt, MD, La Crosse, 1982
Vacancy, 1983
Martin Z Fruchtman, MD, Waukesha, 1983
John J Koch, MD, Prairie du Sac, 1983
James T Houlihan, MD, Woodruff, 1984
Vice Chairman
John L Raschbacher, MD, Waukesha, 1984
Leonard H Wurman, MD, Wausau, 1984
Chairman
Dean Arnold L Brown, MD, Madison
University of Wisconsin Medical School
Dean Edward J Lennon, MD, Milwaukee
Medical College of Wisconsin

CME COMMITTEE

Subcommittee on Accreditation

Bradley G Garber, MD, Osseo
Richard D Sautter, MD, Marshfield
Leonard H Wurman, MD, Wausau
Melvin F Huth, MD, Baraboo
Warren J Holtey, MD, Marshfield
Joseph J Mazza, MD, Marshfield
Jerold J Beerends, MD, West Bend
Eugene Musser, MD, Madison
Paul R Glunz, MD, Beaver Dam
Sherman P Vinograd, MD, Madison

Expiration of term at Annual Meeting of the year designated appears following member's name. Chairman and vice chairman of commissions and committees are elected at the first meeting following the Annual Meeting. The BLUE BOOK is prepared prior to most of these elections; therefore, some commissions and committees will not include these designations.

Governmental Affairs

This commission shall concern itself with all state and federal health legislation, its analysis and communication to the membership; preparing and securing state or federal health legislation for the best interests of the public, scientific medicine, and the medical profession; legislative representation and liaison, state and federal; informing the membership of the Society of important proposed legislation and encouraging members to be active individually in political affairs; liaison between the Society and executive and legislative branches of government.

Membership of the Commission on Governmental Affairs shall include a representative from each of the specialty sections of the Society. These representatives shall be appointed by the specialty sections annually. Such appointments shall be subject to the approval by the Board of Directors. Representatives on the Commission from the specialty sections need not be counted for purposes of a quorum for a meeting of the Commission on Governmental Affairs, but shall have the right to vote.

Thomas P Belson, MD, Waukesha, 1982
Theodore C Fox, MD, Antigo, 1982
Vice Chairman
JD Kabler, MD, Madison, 1982
Chairman
Jack D Edson, MD, Eau Claire, 1983
Robert F Purtell Jr, MD, Milwaukee, 1983
Raymond C Zastrow, MD, Wauwatosa, 1983
Gerald A Gehl, MD, Neenah, 1984
Martin L Janssen, MD, Friendship, 1984
Vacancy, 1984

SECTION REPRESENTATIVES

Allergy & Immunology: *James R Mattson, MD,* Green Bay
Anesthesiology: *John F Kreul, MD,* Madison
Dermatology:
Emergency Medicine:
Family Physicians: *Patrick W Connerly, MD,* Eau Claire
Internal Medicine: *Michael P Mehr, MD,* Marshfield
Medical Faculties:
Neurology: *Henry A Peters, MD,* Madison
Neurosurgery: *Alan B Levin, MD,* Madison
Obstetrics & Gynecology: *James B Torhorst, MD,* Madison
Ophthalmology: *M Thomas Chemotti, MD,* Cedarburg
Orthopedics: *Marvin W Nelson, MD,* Racine
Otolaryngology: *William W Finch, MD,* Madison
Pathology: *Chesley P Erwin, MD,* Milwaukee
Pediatrics: *Carl S Eisenberg, MD,* Milwaukee
Physical Medicine & Rehabilitation: *Richard F Harvey, MD,* Madison
Plastic Surgery: *Vaughn Demergian, MD,* Madison
Psychiatry: *Darold A Treffert, MD,* Fond du Lac
Preventive Medicine: *George H Handy, MD,* Madison
Radiology: *Eugene H Betlach, MD,* Janesville
Residents: *Mark F Liebow, MD,* Madison
Surgery:
Urology: *Raul F Waters, MD,* Madison

———

Medical Examining Board: *George M Daley, MD,* Milwaukee
SMS Auxiliary: *Mrs Susan Eisenberg,* Mequon
EX OFFICIO (Board Chairman): *Darold A Treffert, MD,* Fond du Lac
SMS President: *Albert J Motzel Jr, MD,* Waukesha
SMS President-elect: *Gerald C Kempthorne, MD,* Spring Green

Health Planning

This commission shall be concerned about planning for health care, including facilities and services and their organization to assure availability, access and quality of care; standards, guidelines and regulations affecting health care; distribution of medical services; relationships with allied health personnel; and matters pertaining to the Joint Commission on Accreditation of Hospitals.

This commission also includes representatives of specialty sections/societies and chairmen of Physician HSA Task Forces with voting rights when present, provided they are SMS members, such appointments subject to approval by the Board of Directors.

Edward J Lennon, MD, Milwaukee, 1982
Kermit L Newcomer, MD, La Crosse, 1982
Bruce J Stoehr, MD, Green Bay, 1982
Frederic L Hildebrand, MD, Neenah, 1983
Marvin G Parker, MD, Racine, 1983
Sigurd E Sivertson, MD, Madison, 1983
D Joseph Freeman, MD, Wausau, 1984
Guenther Pohlmann, MD, Milwaukee, 1984
Chairman
Lee M Tyne, MD, Brookfield, 1984

SPECIALTY REPRESENTATIVES
Society
Allergy: *J Brent Kooistra, MD,* Madison
Family Physicians:
Internal Medicine: *Kenneth R Kubsch, MD,* Green Bay
Neurological: *Gamber F Tegtmeyer, MD,* Madison
Neurosurgical:
Obstetrics and Gynecology: *Norman J Schroeder, MD,* Beaver Dam
Pediatrics (Wisconsin Chapter): *Gary R Gutcher, MD,* Madison
Physical Medicine and Rehabilitation: *Albert M Cohen, MD,* Milwaukee
Preventive Medicine: *Richard W Biek, MD,* Milwaukee
Radiological: *Andrew B Crummy, MD,* Madison
Surgeons (Wisconsin Chapter): *John T Mendenhall, MD,* Madison
Surgical: *P Richard Sholl, MD,* Janesville

SMS Section
Anesthesiology: *Ann Bardeen Henschel, MD,* Oconomowoc
Dermatology: *Hal Ridgway, MD,* Madison
Emergency Medicine:
Ophthalmology: *James C Allen, MD,* Madison
Otolaryngology: *Charles H Mann, MD,* Madison
Pathology: *Robert E Carlovsky, MD,* Fond du Lac
Physical Medicine and Rehabilitation: *John L Melvin, MD,* Milwaukee
Radiology: *Marcia J S Richards, MD,* Milwaukee
Resident Physicians: *Joseph Selliken, MD,* Madison

———

Physician Task Force of the Lake Winnebago Area HSA: *Timothy T Flaherty, MD,* Neenah
Southwestern Wisconsin Physician Task Force: *Jan Erlandson, MD,* Monroe

The WISCONSIN MEDICAL JOURNAL gratefully acknowledges publication support of this "Blue Book" issue through a contribution from the Crownhart Memorial Account of the State Medical Society's Charitable, Educational and Scientific Foundation.

Mediation and Peer Review

This commission may have up to 25 members. It shall receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, on matters relating to quality of care, professional ethics, and fees. When necessary, it shall initiate disciplinary or other action as appropriate. It shall serve as the Society's advisory body to private or governmental organizations on matters affecting medical peer review including utilization review, appropriateness of care, fees, and quality assurance. It shall advise and consult with component societies on issues of peer review, mediation, ethics, and discipline in concert with members of the Board of Directors. It shall serve as the initial appellate body for peer review and mediation issues that are appealed from local committees of component societies. It shall coordinate the impaired physician program.

Albert H Adams, MD, Milwaukee, 1982
Domenick S Bruno, MD, Milwaukee, 1982
Ronald J Darling, MD, Waukesha, 1982
John A DeGiovanni, MD, Prairie du Sac, 1982
Richard W Edwards, MD, Richland Center, 1982
Leo R Grinney, MD, Racine, 1982
Charles H Mann, MD, Madison, 1982
Michael R McCormick, MD, Waukesha, 1982
Herman J Dick, MD, Sheboygan, 1983
Melvin F Huth, MD, Baraboo, 1983
Charles E Koepp, MD, Marinette, 1983
Robert E Johnston, MD, Green Bay, 1983
Vice Chairman
D Mark Lochner, MD, Waupaca, 1983
Richard Logan, MD, Madison, 1983
Harry F Weisberg, MD, Milwaukee, 1983
David E Westgard, MD, La Crosse, 1983
Lloyd R Cotts, MD, Rice Lake, 1984
Joseph B Grace, MD, Green Bay, 1984
James M Huffer, MD, Madison, 1984
Thomas F Jennings, MD, West Allis, 1984
Gerald C Kempthorne, MD, Spring Green, 1984
Chairman
John B McAndrew, MD, Oshkosh, 1984
Robert E Phillips, MD, Marshfield, 1984
William E Raduege, MD, Woodruff, 1984
John D Riesch, MD, Menomonee Falls, 1984

MPR COMMITTEES

Coordinating Council on Physician Impairment

Gerald C Kempthorne, MD (State Medical Society), Spring Green
John B McAndrew, MD (State Medical Society), Oshkosh
Harry F Weisberg, MD (State Medical Society), Milwaukee
Ms Gwen Jackson (Medical Examining Board), Milwaukee
Walter L Washburn, MD (Medical Examining Board), Madison
Rudolf W Link, MD (Medical Examining Board), Madison

Medicaid Medical Audit Committee

John A DeGiovanni, MD, Prairie du Sac
Richard W Edwards, MD, Richland Center
Leo R Grinney, MD, Racine
Gerald C Kempthorne, MD, Spring Green
John J Kief, MD, Rhinelander
D Mark Lochner, MD, Waupaca
Richard Logan, MD, Middleton
Virgil L Sharp, DO, Waterloo
G John Weir Jr, MD, Marshfield
David E Westgard, MD, LaCrosse
Alfred D Dally, MD, Madison

Physicians Alliance

This commission shall have 18 members consisting of one for each Society District, except that District 2 shall have two members and District 1 shall have seven members. In addition the President of the State Medical Society, the Chairman of the Board of Directors, and Chairman of the Commission on Governmental Affairs will be ex officio members with vote. Nominations for membership on the commission shall be made by the Board Nominating Committee, but nominees shall be actively solicited from within each district by contact with the county medical societies and the medical staffs of hospitals. The commission shall be concerned with planning, organizing, and implementing appropriate programs to protect, promote, and achieve the socio-economic interests of the members of the State Medical Society of Wisconsin. It shall report to the Board at every regular meeting and annually to the House of Delegates, both as to its operations and policy recommendations.

Harry H Larson, MD, Ashland, 1982
William J Listwan, MD, West Bend, 1982
John O Simenstad, MD, Osceola, 1982
John E Thompson, MD, Nekoosa, 1982
Kenneth M Viste Jr, MD, Oshkosh, 1982
Chairman

Jordon Frank, MD, Waukesha, 1983
Vice Chairman

LaVern H Herman, MD, Waukesha, 1983
Jack M Lockhart, MD, La Crosse, 1983
Charles E Pechous Jr, MD, Kenosha, 1983
Vacancy, 1983

Thomas G Dehn, MD, Milwaukee, 1984
Joseph C Diraimondo, MD, Manitowoc, 1984
C Robert Jackson, MD, Madison, 1984
Russell A Quirk, MD, Racine, 1984
Richard Stone, MD, Milwaukee, 1984

Ex officio voting members:
President, State Medical Society
Chairman of the Board of Directors
Chairman, Commission on Governmental Affairs

SPECIALTY REPRESENTATIVES

Allergy Society and Section: *Robert J Kriz, MD,* Madison
Anesthesiology Section: *Richard A Manhart, MD,* Cross Plains
Dermatology Section: *Robert A McDonald, MD,* Madison
Family Physicians Section: *Richard K Chambers, MD,* Hartland
Medical Faculties Section: *Mark J Ciccantelli, MD,* Wauwatosa
Neurology Section: *Michael P McQuillen, MD,* Milwaukee
Neurosurgical Society and Section: *Allan B Levin, MD,* Madison
Obstetrics-Gynecology Section: *William J O'Leary, MD,* LaCrosse
Ophthalmology Section: *Edwin B Bercovici, MD,* Milwaukee
Resident Physicians Section: *Joseph Selliken, MD,* Madison
Pediatrics Section: *John R Guy, MD,* Waukesha
Physical Medicine and Rehabilitation Section: *William J LaJoie, MD,* Waukesha
Plastic Surgery Section: *Sidney K Wynn, MD,* Milwaukee
Preventive Medicine Section: *Richard W Biek, MD,* Milwaukee
Surgery Section:
Otolaryngological Society: *John E Clemons, MD,* LaCrosse
Pathology Society: *Dean M Connors, MD,* Madison
Psychiatry Society: *Robert F Goerke, MD,* Milwaukee
Urology Section: *Randle E Pollard, MD,* Milwaukee
Radiology Section: *Timothy T Flaherty, MD,* Neenah
Radiological Society: *Donald P Babbitt, MD,* Milwaukee
Dematological Society: *Derek J Cripps, MD,* Madison
Neurological Society: *Phiroze L Hansotia, MD,* Marshfield
Orthopedic Society: *Richard C Wixson, MD,* Madison
Pathology Section: *Kenneth A Stormo, MD,* Fond du Lac
Radiation Oncology Society: *John C Kirkpatrick, MD,* Madison
Neurosurgical Society: *Stephen M Cushman, MD,* Racine, or *Mohammed Raffiullah, MD,* Racine
Emergency Medicine Section: *Timothy J Helz, MD,* Hartland
Surgical Society: *Russell P Sinaiko, MD,* Madison
Orthopedic Section: *Paul K Odlund, MD,* Janesville
American Academy of Pediatrics, Wisconsin Chapter: *Rolv Slungaard, MD,* LaCrosse
Obstetrics-Gynecology Society: *C Weir Horswill, MD,* Middleton
Surgical Society: *Galen Thomas, MD,* Milwaukee

PAC COMMITTEES

Medical Liability Committee

Russell A Quirk, MD, Racine, *Chairman*
Norman O Becker, MD, Fond du Lac
Paul A Jacobs, MD, Milwaukee
Fred C Kriss, MD, Madison
Walter D Moritz, MD, Fort Atkinson
Eugene J Nordby, MD, Madison
William L Treacy, MD, Milwaukee
Thomas G Dehn, MD, Bayside
Vaughn Demergian, MD, Madison

Federal Legislation Committee

Robert F Purtell Jr, MD, Milwaukee, *Chairman*
Raymond C Zastrow, MD, Milwaukee
David R Weber, MD, Fond du Lac
Michael P Mehr, MD, Marshfield
Carl S Eisenberg, MD, Milwaukee
Roland R Liebenow, MD, Lake Mills
Robert L Johnson, MD, Wisconsin Rapids
Paul S Johnson, MD, Racine
Ex-Officio
J D Kabler, MD, Madison
Susan Eisenberg, Mequon

Ad Hoc Committee on Health Practitioners

Michael P Mehr, MD, Marshfield, *Chairman*
Roger L von Heimburg, MD, Green Bay
Allen O Tuftee, MD, Beloit
Paul S Haskins, MD, River Falls
J D Kabler, MD, Madison
Theodore C Fox, MD, Antigo
Carl S Eisenberg, MD, Milwaukee

Public Information

This commission shall be concerned about the members of this Society and their image with the public. It shall plan and execute programs of effective public information and health education, assist component societies in the conduct of similar programs, develop effective media relations, and recruit and retain physician members of the Society and encourage their active participation in the affairs of the county and state societies and the American Medical Association.

Stanley J Graiewski, MD, Oshkosh, 1982
Herbert F Sandmire, MD, Green Bay, 1982
Chairman

Charles Sorensen, MD, Wisconsin Rapids, 1982
Joseph W Edgett Jr, MD, La Crosse, 1983
William J Maurer, MD, Marshfield, 1983
Mark J Popp, MD, Brookfield, 1983
Vice Chairman

Wallace MacMullen, MD, Green Bay, 1984
Richard W Shropshire, MD, Madison, 1984
Vacancy, 1984

Wisconsin Medical Journal

The *Wisconsin Medical Journal* shall be the official journal of the Society. An editorial board consisting of the medical editor as chairman and six additional members shall be responsible for all scientific, editorial, and business affairs of the Journal. An editorial director, serving as chairman of a group of no less than five editorial associates, shall be responsible for regularly providing items of editorial opinion for publication in the editorial pages of the Journal.

EDITORIAL BOARD

Victor S Falk, MD, Edgerton, 1982
Chairman and *Medical Editor*
Wayne J Boulanger, MD, Milwaukee, 1982
Harold H Scudamore, MD, Monroe, 1982
Dean M Connors, MD, Madison, 1983
Melvin F Huth, MD, Baraboo, 1983
M C F Lindert, MD, Milwaukee, 1984
Richard D Sautter, MD, Marshfield, 1984
Garrett A Cooper, MD, Madison, Emeritus

EDITORIAL ASSOCIATES (appointed annually by Board of Directors)

Wayne J Boulanger, MD, Milwaukee
Chairman and *Editorial Director*
Victor S Falk, MD, Edgerton, *Medical Editor*
Russell F Lewis, MD, Marshfield
John P Mullooly, MD, Milwaukee
Raymond A McCormick, MD, Green Bay

* * *

COMMITTEES

Aging and Extended Care Facilities

This committee shall be concerned about the process of aging and means to achieve the best possible health care for the aged, including nursing home care.

Elston L Belknap Jr, MD, Madison, 1982
Edward L Perry, MD, La Crosse, 1982
Leslie H Stone, MD, Oshkosh, 1982
Frederick W Blancke, MD, Madison, 1983
Vice Chairman
Steven R Gambert, MD, Milwaukee, 1983
Joseph C Springberg, MD, Beloit, 1983
Terrence N Hart, MD, Brookfield, 1984
Nicholas L Owen, MD, Milwaukee, 1984
Chairman
Wilbur E Rosenkranz, MD, Mukwonago, 1984
Gertrude E Howe, MD, Fish Creek (emeritus)

Alcoholism and Other Drug Abuse

This committee shall be concerned about prevention, treatment, and rehabilitation for persons affected by alcoholism and any other type of drug abuse.

Roland E Herrington, MD, Milwaukee, 1982
Marwood E Wegner, MD, St Croix Falls, 1982
David L Nelson, MD, Stoughton
Dennis G Biros, MD, La Crosse, 1983
Michael C Gordon, MD, Janesville, 1983
Darold A Treffert, MD, Winnebago, 1983
Nunilo L Bugarin, MD, Tomahawk, 1984
Fred H Koenecke, MD, Madison, 1984
Warren H Williamson, MD, Racine, 1984

Environmental and Occupational Health

This committee may have up to 15 members and shall be concerned with the health and safety of persons in relation to their environment, including matters relating to occupational and rural health.

Vernon N Dodson, MD, Madison, 1982
Edward P Horvath Jr, MD, Marshfield, 1982
George H Handy, MD, Madison, 1982
Larry A Lindesmith, MD, La Crosse, 1982
Charles W Fishburn, MD, New Berlin, 1982
Melvin S Blumenthal, MD, Monroe, 1983
Robert W Page, MD, Marshfield, 1983
Wendelin W Schaefer, MD, Sheboygan, 1983
Chairman
Frank A Walker, MD, Brookfield, 1983
Carl Zenz, MD, West Allis, 1983
Vice Chairman
Henry A Anderson III, MD, Madison, 1984
John J Beck, MD, Sturgeon Bay, 1984
Timothy A Correll, MD, Dodgeville, 1984
Donald M Rowe, MD, Kohler, 1984
John T Schmitz, MD, Milwaukee, 1984
Mrs W W (Jame) Schaefer, Sheboygan, Auxiliary

Maternal and Child Health

This committee shall be concerned about all aspects of health in pregnancy, childbirth and children, with special emphasis on the reduction of maternal mortality and the prevention of disease or disability in children.

Edward J Buerger, MD, Waukesha, 1982
Kilian H Meyer, MD, Richland Center, 1982
Curtis R Weatherhogg, MD, Madison, 1982
Vice Chairman
Gary R Gutcher, MD, Madison, 1983
John E Inman, MD, Monroe, 1983
Joanne Selkurt, MD, Whitehall, 1983
Daniel F Johnson, MD, Eau Claire, 1984
Sharon L Maby, MD, Marshfield, 1984
Walter R Schwartz, MD, Wauwatosa, 1984
Chairman

SUBCOMMITTEE

Study Committee on Maternal Mortality Survey

Harold Borkowf, MD, Milwaukee
Richard C Brown, MD, Eau Claire
Gloria M Halverson, MD, Waukesha
Perry A Henderson, MD, Madison
Frederick J Hofmeister, MD, Wauwatosa
Stanley A Korducki, MD, Milwaukee
Thomas A Leonard, MD (Emeritus), Middleton
Ronald W Olson, MD, Madison
Ben M Peckham, MD, Madison
Robert P Reik, MD, Wauwatosa
Herbert F Sandmire, MD, Green Bay
Albert H Stahmer, MD, Wausau

continued next page

Medicine and Religion

This committee shall be concerned about the medical-spiritual values of health care and the development of closer relationships between physicians and clergy to permit discussion of common problems in the total treatment and care of patients.

John S Harris, MD, Appleton, 1982
John P Mullooly, MD, Milwaukee, 1982
John O Simenstad, MD, Osceola, 1982
Chairman
E Basil Jackson, MD, Milwaukee, 1983
John K Scott, MD, Madison, 1983
Maxwell H S Weingarten, MD, Milwaukee, 1983
Frank J Cerny, MD, Fond du Lac, 1984
William O Myers, MD, Marshfield, 1984
Richard W Shropshire, MD, Madison, 1984

Mental Health

This committee shall be concerned with all aspects of mental health as an equal part of the patient's total well-being.

David P Donarski, MD, Green Bay, 1982
Vice Chairman
William W Garitano, MD, Marshfield, 1982
William H Heywood, MD, Marshfield, 1982
Pauline M Jackson, MD, La Crosse, 1982
Chairman
Warren A Olson, MD, Madison, 1982
Francis M Forster, MD, Madison, 1983
Edward D Meyer, MD, Oshkosh, 1983
Theodore J Nereim, MD, Mount Horeb, 1983
Robert F Goerke, MD, Milwaukee, 1984
Charles W Landis, MD, Milwaukee, 1984
Clarence E Moore, MD, Fond du Lac, 1984

Safe Transportation

This committee shall be concerned about the health and safety of all who may be affected by the use of vehicles of transportation on land, water, or in the air.

Eugene E Eckstam, MD, Monroe, 1982
Ralph F Hudson, MD, Eau Claire, 1982
Walter F Smejkal, MD, Manitowoc, 1982
James M Huffer, MD, Madison, 1983
Elmer E Johnson, MD, Madison, 1983
Clarence E Moore, MD, Fond du Lac, 1983
Frederick Bunkfeldt Jr, MD, Milwaukee, 1984
Glenn C Hillery, MD, Lancaster, 1984
James L Weygandt, MD, Sheboygan Falls, 1984
Chairman

School Health

This committee shall be concerned about protecting and improving the health of those attending the public or private schools of this state, including matters related to athletics.

Parnell Donahue, MD, Hartford, 1982
James C H Russell, MD, Ft Atkinson, 1982
Jack I Spear, MD, Richland Center, 1982
William T Brodhead, MD, Madison, 1983
Lawrence K Siegel, MD, Waukesha, 1983
Frank A Walker, MD, Brookfield, 1983
George H Handy, MD, Madison, 1984
Horace K Tenney III, MD, Madison, 1984
Vacancy, 1984

Women Physicians

This committee shall serve as liaison and women's advocate with other commissions and committees of the State Medical Society. It shall encourage state, county, and specialty societies to make special efforts to recruit women physicians to membership in organized medicine, subsequently to consider them for leadership positions based on their professional capabilities rather than as women physicians. It shall promote medical education that is sensitive and responsive to women's healthcare needs and enhance educational opportunities for women. It also shall serve as a resource to the State Medical Society, other groups, and individuals on women's health issues. It shall consist of nine members appointed by the Board of Directors.

Russell F Lewis, MD, Marshfield, 1982
Mrs Donald A Peterson, Madison, Auxiliary, 1982
Patricia J Stuff, MD, Bonduel, 1982
Carl S Eisenberg, MD, Milwaukee, 1983
Pauline M Jackson, MD, La Crosse, 1983
Sandra L Osborn, MD, Madison, 1983
Kathryn C Bemmann, MD, Waukesha, 1984
Pamela M Beranek, MD, Menomonee Falls, 1984
Lucille B Glicklich, MD, Milwaukee, 1984 ■

House of Delegates Nominating Committee

State Medical Society of Wisconsin

1981-1982

DISTRICT 1
Clifton E Peterson MD, 1400-75th St, Kenosha 53140
John D Riesch MD, PO Box 427, Menomonee Falls 53051
Kenneth M Smigielski MD, 3615 W Oklahoma Ave, Milwaukee 53215
Jerome J Veranth MD, 5605 Washington Ave, Racine 53406

DISTRICT 2
Sandra L Osborn MD, 1912 Atwood Ave, Madison 53704, *Chairman*
James J Tydrich MD, 1313 W Seminary St, Richland Center 53581, *Secretary*

DISTRICT 3
Vernon M Griffin MD, 1040 Division St, Mauston 53948

DISTRICT 4
John E Thompson MD, 315 First St, Nekoosa 54457

DISTRICT 5
Kenneth M Viste Jr MD, 100 Stoney Beach Rd, Oshkosh 54901

DISTRICT 6
John E Kraus MD, 1510 Main St, Marinette 54143

DISTRICT 7
Merne W Asplund MD, 1518 Main St, Bloomer 54724

DISTRICT 8
Clarence M Scott MD, 318-21st Ave E, Superior 54880

SPECIALTY SECTIONS
Joel E Taxman MD, 1622 W Wisconsin Ave, Milwaukee 53233

RELATED ORGANIZATION BOARDS: 1981-82

SMS Realty Corporation *Trustees*
Eugene J Nordby MD, Madison, 1984, *President*
Richard W Edwards MD, Richland Center, 1982, *Vice President*
John J Foley MD, Menomonee Falls, 1983, *Treasurer*

SMS Services, Inc *Directors*
William P Crowley Jr MD, Madison, 1983, *President*
John P Mullooly MD, Milwaukee, 1984, *Vice President*
Richard W Edwards MD, Richland Center, 1982, *Treasurer*
Earl R Thayer, Madison, 1984, *Secretary*
Timothy T Flaherty MD, Neenah, 1982
Joseph M Jauquet MD, Ashland, 1982
Paul G LaBissoniere MD, Milwaukee, 1983
Allen O Tuftee MD, Beloit, 1983
John J Foley MD, Menomonee Falls, 1984

Special Officers
H B Maroney II, Madison, *Assistant Secretary*
LeRoy A Johnson, Madison, *Executive Vice President*

Charitable, Educational and Scientific Foundation
(See listing elsewhere in this issue)

PAST PRESIDENTS OF THE STATE MEDICAL SOCIETY OF WISCONSIN: 1953-1981

This is a partial listing. The complete listing from 1841 to 1972 appeared in the January 1973 issue.

H Kent Tenney, MD, Madison 1953-1954
†Arthur J McCarey, MD, Green Bay 1954-1955
Ervin L Bernhart, MD, Milwaukee 1955-1956
†L Otis Simenstad, MD, Osceola 1956-1957
†Harry E Kasten, MD, Beloit 1957-1958
†Jerome W Fons, MD, Milwaukee 1958
†William B Hildebrand, MD, Menasha 1959-1960
Edmund D Sorenson, MD, Elkhorn 1960-1961
Leif H Lokvam, MD, Kenosha 1961-1962
Nels A Hill, MD, Madison 1962-1963
†William J Egan, MD, Milwaukee 1963-1964
William P Curran, MD, Antigo 1964-1965
†John H Houghton, MD, Wisconsin Dells 1965-1966
†Frank E Drew, MD, Milwaukee 1966-1967
Harold J Kief, MD, Fond du Lac 1967-1968
†William D James, MD, Oconomowoc 1968-1969
Robert E Callan, MD, Milwaukee 1969-1970
Jerry W McRoberts, MD, Sheboygan 1970-1971
George A Behnke, MD, Kaukauna 1971-1972
Robert F Purtell, MD, Milwaukee 1972-1973
Gerald J Derus, MD, Madison 1973-1974
John E Dettmann, MD, Green Bay 1974-1975
Howard L Correll, MD, Arena 1975-1976
Charles J Picard, MD, Superior 1976-1977
Roy B Larsen, MD, Wausau 1977-1978
Jules D Levin, MD, Milwaukee 1978-1979
Darold A Treffert, MD, Fond du Lac 1979-1980
Russell F Lewis, MD, Marshfield 1980-1981

†Deceased

Wisconsin's EPSDT Program

a time for physician involvement

The Stote of Wisconsin is osking physicions to enroll os screeners for its Eorly ond Periodic Screening, Diagnosis and Treatment (EPSDT) progrom. EPSDT, administered by the Divisian of Health and financed with stote ond federal funds through the Medicol Assistance Program, is o comprehensive heolth promotion and prevention pockage for children ond young adults under age 21 who ore eligible for Medical Assistance.

The EPSDT program offers physicions outreoch services, office referrols for screening plus followup services to assure thot subsequent diagnosis and treatment referrals are kept.

The screening portion of the EPSDT program consists of simple, standard procedures conducted according to a periodicity schedule which were designed specifically for physicians and opproved by the EPSDT physicion committee.

The State Medicol Society of Wisconsin's Committee on Maternol and Child Health encourages physicians to enroll as EPSDT screeners today. To enroll, or for further information contact:

Wisconsin Divisian of Heolth
Bureau of Health Care Financing
EPSDT Sectian
PO Box 39
Madison, Wisconsin 53701

or call 608/266-7164

COUNTY MEDICAL SOCIETIES

Presidents (P) and Secretaries (S); Executive Secretaries (ES), Treasurers (T), and Executive Vice Presidents (EVP)

ASHLAND-BAYFIELD-IRON
P—Garfield W Brown, MD
2101 Beaser Ave, #5
Ashland, WI 54806
S—Edward M Vernier, MD
2101 Beaser Ave, #9
Ashland, WI 54806

BARRON-WASHBURN-BURNETT
P—James A Rugowski, MD
Rt 1, Box 146A
Cumberland, WI 54829
S—Donald E Riemer, MD
PO Box 127
Cumberland, WI 54829

BROWN
P—Louis D Phillipp, MD
704 S Webster
Green Bay, WI 54301
S—James R Mattson, MD
501 S Military Ave
Green Bay, WI 54301
T—Frederick J Lamont, MD
123 N Military Ave
Green Bay, WI 54303
ES—Ms Bernice Mangless
501 S Military Ave
Green Bay, WI 54301

CALUMET
P—Arturo M Ylagan, MD
26 School St
Chilton, WI 53014
S—James C Pinney, MD
507-C West Main St
Hilbert, WI 54129

CHIPPEWA
P—Romeo B Sangalang, MD
Rt 5
Chippewa Falls, WI 54729
S—Richard D Kennedy, MD
3203 Stein Blvd
Eau Claire, WI 54701

CLARK
P—Narasimhulu Neelagaru, MD
110 Park St
Neillsville, WI 54456
S—Frederico P Gregorio, MD
216 Sunset Place
Neillsville, WI 54456

COLUMBIA-MARQUETTE ADAMS
P—Thomas E Henney, MD
916 E Silver Lake Dr
Portage, WI 53901
S—Frederick H Bronson, MD
Rt 2, Fox Glen Rd
Portage, WI 53901
ES—Mrs Elayne Hanson
PO Box 352
Portage, WI 53901

CRAWFORD
P—Thomas F Farrell, MD
323 S Beaumont Rd
Prairie du Chien, WI 53821
S—Michael S Garrity, MD
610 East Taylor St
Prairie du Chien, WI 53821

DANE
P—David W Semian, MD
1 South Park St, #225
Madison, WI 53715
S—Dolores A Buchler, MD
600 Highland Ave, H4/634
Madison, WI 53792

DODGE
P—James S Berry, MD
130 Warren St
Beaver Dam, WI 53916
S—Vicki R Prell, MD
130 Warren St
Beaver Dam, WI 53916

DOOR-KEWAUNEE
P—Ferrin C Holmes, MD
PO Box 447
Sturgeon Bay, WI 54235
S—Michael R McFadden, MD
PO Box 447
Sturgeon Bay, WI 54235

DOUGLAS
P—William D Berg, MD
2430 Logan Ave
Superior, WI 54880
S—John F Franco, MD
3600 Tower Ave
Superior, WI 54880

EAU CLAIRE-DUNN-PEPIN
P—Thomas J Doyle Jr, MD
3203 Stein Blvd
Eau Claire, WI 54701
S—Gene G Enders, MD
733 W Clairemont Ave
Eau Claire, WI 54701

FOND DU LAC
P—David F Sweet, MD
80 Sheboygan St
Fond du Lac, WI 54935
S—William G Sybesma, MD
80 Sheboygan St
Fond du Lac, WI 54935
T—Robert E Carlovsky, MD
222 Cottage Ave
Fond du Lac, WI 54935

FOREST
P—Enzo F Castaldo, MD
Laona, WI 54541
S—Burton S Rathert, MD
101 West Washington
Crandon, WI 54520

GRANT
P—John M McKichan, MD
1370 North Water St
Platteville, WI 53818
S—Robert E Stader, MD
235 North Madison
Lancaster, WI 53813

GREEN
P—Geoffrey L Tullett, MD
1515 Tenth St
Monroe, WI 53566
S—George E Breadon, MD
1515 Tenth St
Monroe, WI 53566

GREEN LAKE-WAUSHARA
P—Alonzo R Giminez, MD
PO Box 350
Berlin, WI 54923
S—Michael E Tieman, MD
Rt 2
Berlin, WI 54923

IOWA
P—Timothy A Correll, MD
109 West Fountain St
Dodgeville, WI 53533
S—Harald P L Breier, MD
PO Box 185
Montfort, WI 53569

JEFFERSON
P—John S Garman, MD
144 W Madison St
Waterloo, WI 53594
S—David C Grout, MD
426 McMillen St
Fort Atkinson, WI 53538

JUNEAU
P—Clayton L Weston, MD
600 South Monroe
New Lisbon, WI 53950
S—Jack Strong, MD
1040 Division St
Mauston, WI 53948

KENOSHA
P—A James Bennett, MD
3734 Seventh Ave, #22
Kenosha, WI 53140
S—Anoo P Patel, MD
5942 Sixth Ave
Kenosha, WI 53140

LA CROSSE
P—George P Gersch, MD
431 West Garland St
West Salem, WI 54669
S—Thomas P Lathrop, MD
1836 South Ave
La Crosse, WI 54601

LAFAYETTE

LANGLADE
P—John E McKenna, MD
PO Box 400
Antigo, WI 54409
S—Theodore C Fox, MD
213 Fifth Ave
Antigo, WI 54409

LINCOLN
P—Geoffrey C Kloster, MD
1205 O'Day St
Merrill, WI 54452
S—Nunilo L Bugarin, MD
221 East Washington Ave
Tomahawk, WI 54487

MANITOWOC
P—Barry V Bast, MD
600 York St
Manitowoc, WI 54220
S—Steven D Driggers, MD
600 York St
Manitowoc, WI 54220

MARATHON
P—James D Kramer, MD
2727 Plaza Dr
Wausau, WI 54401
S—Julio C Davila, MD
333 Pine Ridge Blvd
Wausau, WI 54401

MARINETTE-FLORENCE
P—Kenneth G Pinegar, MD
2500 Hall Ave
Marinette, WI 54143
S—Steven H Hoyme, MD
801 Wells St
Marinette, WI 54143

MILWAUKEE
P—Charles W Landis, MD
2350 N Lake Dr
Milwaukee, WI 53211
S—Marvin Glicklich, MD
411 E Mason St
Milwaukee, WI 53202
EVP—Mr Michael McManus
411 E Mason St
Milwaukee, WI 53202

MONROE
P—Gustave A Landmann, MD
PO Box 729
Tomah, WI 54660
S—Jack D Brown, MD
202 South K St
Sparta, WI 54656

OCONTO
P—John R Culver, MD
150 North Main St
Oconto Falls, WI 54154

S—Clyde E Siefert, MD
164 North Main St
Oconto Falls, WI 54154

ONEIDA-VILAS
P—Benn A Haynes, MD
830 Messer St
Rhinelander, WI 54501

S—Jeffrey V Christensen, MD
2 East Ocala
Rhinelander, WI 54501

OUTAGAMIE
P—William R Richards, MD
900 East Grant St
Appleton, WI 54911

S—C William Freeby, MD
229 South Morrison St
Appleton, WI 54911

OZAUKEE
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THE OPTOMETRIST REFERRAL LAW

IN 1977 THE Wisconsin Legislature enacted a law permitting optometrists in Wisconsin to use some topical drugs. The law, Chapter 280, Laws of 1977, includes a *mandatory* referral section—the first of its kind in this state. It is reprinted below since some physicians undoubtedly will be receiving referrals in the near future.

449.19 Referral to other medical specialists

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Copies of the new "1981-82 Legislative Directory" prepared by the Physicians Alliance Division of the State Medical Society are now available. The Directory provides the names, addresses and telephone numbers of the Wisconsin Congressional Delegation and State Assembly and Senate members for quick and easy access. Contact the SMS Physicians Alliance Office. ■

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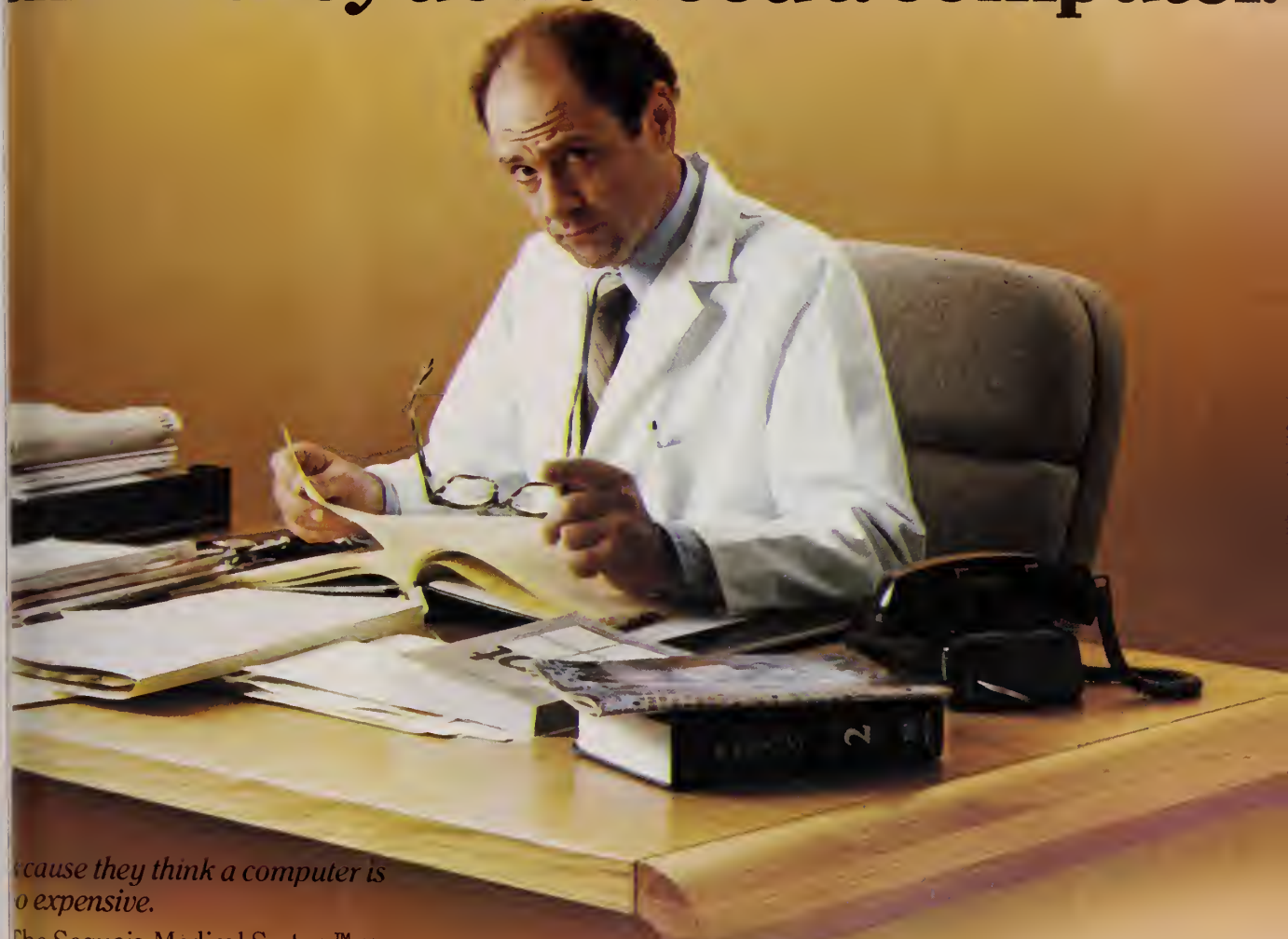

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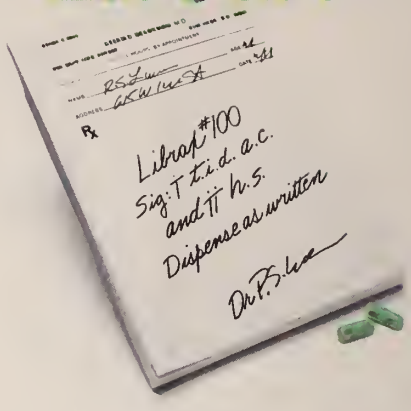

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As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

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Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga, M.T. et al: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York Raven Press, 1978, pp 391-404.

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SPECIALTY CERTIFICATION

WISCONSIN PHYSICIANS are reminded that it is their responsibility, as well as to their advantage, to keep WPS-Medicare informed of any change in their specialty or certification status. To alleviate any confusion, each physician should be sure that the same specialty is shown with the various societies; *eg,* AMA, State Medical Examining Board and the State Medical Society. There have been some instances where a different specialty was shown with each organization. Written documentation of such changes should be directed to the WPS-Medicare insurance company office, ATTENTION-CPCU (Central Provider Control Unit). If you have any questions concerning the specialty WPS-Medicare currently has on file for you, contact Mrs Johnson, CPCU, (608) 221-4711, ext 420.

Wisconsin Weight Loss Guide

A 22-page booklet developed by a registered dietitian to be consistent with current nutrition practices. It was written for adults, 19 years of age and older. The calorie levels for men and women vary, depending upon the type of milk the individuals choose to consume. The emphasis of this guide is on the combination of modifying eating behavior with the consumption of a nutritionally adequate, low-calorie diet. The booklet is available without charge from the **American Dairy Association of Wisconsin,** 4337 West Beltline Highway, Madison, Wisconsin 53711. Indicate the quantity desired.

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1981-1982

Wisconsin Society of Anesthesiologists, Sept 18-20, 1981, Lake Lawn, Lake Delavan

Wisconsin Dermatological Society, Oct 24, 1981, Froedtert Memorial Lutheran Hospital, Milwaukee; and Feb 27, 1982, University of Wisconsin Center for Health Sciences, Madison

Wisconsin Neurosurgical Society, September 18-19, 1981, Madison

Wisconsin Society of Obstetrics & Gynecology, June 11-13, 1981, Telemark Lodge, Cable

Wisconsin Section, American College of Obstetricians & Gynecologists (District VI), Sept 9-12, 1981, Minneapolis, Minn

Wisconsin Society of Otolaryngology, Aug 29-30, 1981, Maxwelton Braes Resort, Baileys Harbor

Wisconsin Society of Pathologists, October 1981

Wisconsin Chapter, American Academy of Pediatrics, Sept 11-12, 1981, University of Wisconsin Clinical Science Center, Madison

Wisconsin Radiological Society, Oct 10, 1981, Concourse Hotel, Madison

***

SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, May 13-15, 1982, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
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Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was created in 1955 to permit members and other friends to present gifts or grants to projects vitally affecting medicine and public health. Its initial fund was used for student loans, but the Foundation's scope of interest has grown with the increased volume of financial contributions to worthy projects.

STUDENT LOANS. Since its inception, the Student Loan Program has helped students prepare for careers in medicine, nursing, dentistry, pharmacy, and allied health fields. Funds for those loans have been given to the Foundation to administer according to the wishes of the donors.

CHARITABLE ASSISTANCE. Through the Foundation there is an opportunity for professional persons to assist their colleagues in need. Personal hardship strikes at physicians and their families as well as others.

MEDICAL STUDENT EXTERNSHIP PROGRAM. This is a newer Foundation project which has been highly successful. It provides an eight-week externship with a family physician for students who have completed their freshman year of medical school. Participating students receive fellowship grants from the Foundation.

RESEARCH ACTIVITY. Research projects on a variety of topics have been done with Foundation support. The Foundation is available to assist in planning, administering, and funding investigations of a scientific or medical socio-economic nature.

CONTINUING MEDICAL EDUCATION. Educational activity, in the form of postgraduate teaching programs, is a major thrust of the Foundation. Among these programs are a Speakers Service to county medical societies, regional "in-depth" programs, and special conferences and lectures on such subjects as medical aspects of mental retardation, prematurity, the newborn, stroke, and athletic injuries as well as many other medical subjects.

Since 1975, the accreditation of continuing medical education programming of Wisconsin hospital and specialty groups has been implemented through the Foundation.

OPPORTUNITIES FOR GIVING. Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Gifts may be unrestricted, restricted, or earmarked for specific purposes of interest to the donor.

In addition, service can be provided to those who wish to establish a Living Trust by naming the Foundation as trustee. Use of this mechanism can result in an immediate tax advantage for the donor while providing a guaranteed income for life. The principal would revert to the Foundation upon death of the donor.

ALL TYPES OF CONTRIBUTIONS TO THIS FOUNDATION ARE TAX-DEDUCTIBLE.

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE AESCULAPIAN SOCIETY of the State Medical Society's CES Foundation is seeking more members for support of its projects in this interesting and rewarding field. Recently two other Foundation groups involved in medical history were combined with the Aesculapian Society—the Permanent Commission to the Museum of Medical Progress and the Academy of Medical History—to make a stronger organization. The Society is now charged with the promotion and operation of the Museum of Medical Progress at Prairie du Chien as well as the preservation of Wisconsin's medical history. Although medical families comprise a large percentage of the membership, anyone who is interested in the group's objectives is eligible to belong. A newsletter is published quarterly to keep the membership aware of ongoing activities and a general membership meeting is held annually at the time of the Annual Meeting of the State Medical Society.

The Aesculapian Society has more than 900 members: it welcomes many more. The annual donation is $10 for regular or $25 for supporting membership. Make your check payable to the CES Foundation—Aesculapian Society, and mail to Box 1109, Madison, Wis 53701.

CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION
OF THE STATE MEDICAL SOCIETY OF WISCONSIN

THE FOUNDATION is a non-profit, non-stock corporation under Wisconsin statutes. Governing power is vested in a Board of Trustees composed of the Board of Directors and Officers of the State Medical Society of Wisconsin and up to 10 elected nonmedical persons. In addition each of the 55 component county societies may elect a representative who is considered a corporate member of the Board of Trustees. Although the membership of the Board of Trustees numbers over 90, the Officers and Executive Committee constitute an efficient working body in governing the routine affairs of the Foundation. The Officers of the State Medical Society, the Officers of the Foundation, and certain elected trustees constitute the Executive Committee of the Board of Trustees. A meeting of the entire Board is held at least annually. Officers are elected at that time. The Executive and other committees meet periodically throughout the year. The Foundation's organization insures continuing liaison at the county medical society level throughout Wisconsin and an integration with the governing body of the State Medical Society itself. Such an arrangement assures a personal and realistic approach to Foundation activities.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence in persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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Tel 608/266-1511
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Tom Johnson

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- Liaison with Health Systems Agencies and review of their plans and budgets
- Coordination of categorical health planning process
- Review of categorical health plans
- Liaison with agencies (public and private) that implement the State Health Plan
- Service licensure
- Development of health facilities plan
- Review of categorical grants appeal

Health Care Financing 266-2522
- Administration of the Medical Assistance Program
- EPSDT—Early and periodic screening, diagnosis and treatment for children and other screening activities
- Hospital rate review

Quality Compliance 267-7185
- Title 18 and Title 19 certification
- Hospital and nursing home standard setting and enforcement
- Patient care evaluation
- Construction and plan review
- Development of facilities standards

Community Health & Prevention 267-9008
- Development and promotion of prevention programs
- Standard epidemiology
- Environmental epidemiology
- Immunization activities
- Communicable diseases
- Chronic diseases
- Participation in preventive efforts within and outside the Department of Health and Social Services
- Promotion of research into major causes of illness and death and sponsorship of demonstration projects designed to reduce and eliminate root causes
- Laboratory certification
- Public health nursing
- Public health nutrition
- Dental health
- Maternal and child health
- Family planning

Institutional Health Services 267-7170
- Assurance of sufficient levels of physical health care for all inmates in correctional institutions and at Central State Hospital
- Management of the provision of such services to insure effectiveness and efficiency
- Recruitment and staffing of health care positions in the correctional institutions

Environmental Health ..... 266-2593 (1400 E Washington Ave, Madison 53702)
- Certification of Grade A milk
- Inspection of hotels, restaurants and food vending services where not performed by local public health agencies
- General environmental sanitation
- Recreational inspection
- Radiation protection
- Occupational health services
- Development of emergency medical services systems

Health Statistics 266-1334
- Vital Statistics
- Resource data
- Demographic and special analysis
- Services data

Bureau of Health Statistics Division of Health

The Bureau is the custodian of birth, death, marriage and divorce records for the state (ss. Chapter 69). Also, the Bureau has a contract with the National Center for Health Statistics for collection of vital statistics and partial funding from the Health Care Financing Administration for the collection of data on hospital discharge, health manpower, and health facilities. Several other projects are being carried out in areas such as cancer reporting, blood alcohol reporting, and emergency medical care. Another of the Bureau's activities is the production of annual population estimates for Wisconsin counties . . . a part of the Federal-State Cooperative Program of the Bureau of the Census. Inquiries may be made to: Raymond D Nashold, Director, Bureau of Health Statistics, PO Box 309, Madison, WI 53701.

REGIONAL OFFICES
Division of Health

1—MADISON 53719
5712 Odana Road
Tel 608/266-2245

2—MILWAUKEE 53216
6815 W Capitol Dr
Tel 414/466-9763

3—FOND DU LAC 54935
485 S Military Rd; PO Box 269
Tel 414/922-1290

4—GREEN BAY 54304
1298 Lombardi Ave
Tel 414/497-3219

5—LACROSSE 54601
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3550 Mormon Coulee Rd
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7—WISCONSIN RAPIDS 54494
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8—Information should be obtained from Eau Claire District

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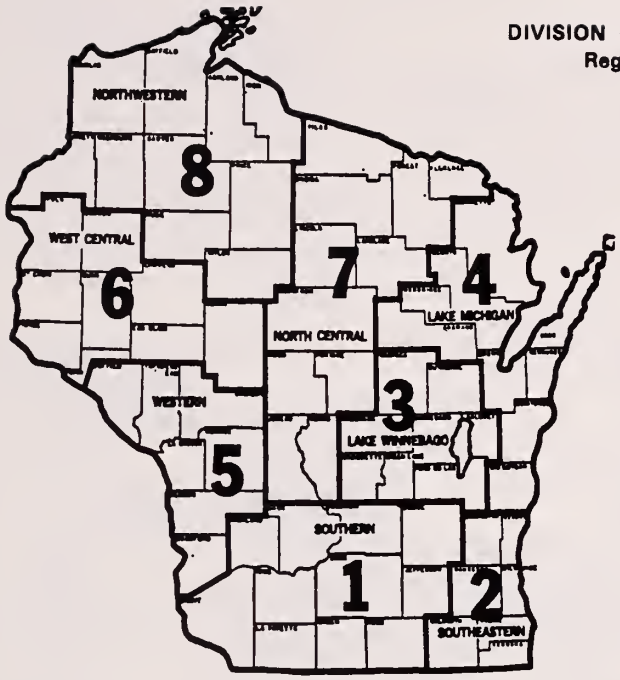

DIVISION OF HEALTH
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KENNETH L RENTMEESTER

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* * *

STAFF: Division of Health, Bureau of Planning, Room 280, One West Wilson St, Madison, Wis 53702 (phone 608/266-6652)

New Administrator Division of Health

KENNETH L RENTMEESTER, 34, on April 14 was appointed Administrator of the State Division of Health by Donald Percy, Secretary of the Department of Health and Social Services. Rentmeester, Director of the Portage County Community Human Services Department, assumed his new duties on June 15. He succeeds Terry Willkom who had been Acting Administrator of the Division for several months. Willkom has resumed his full-time responsibilities as DHSS Deputy Secretary.

Rentmeester was employed by Portage County in 1978 as director of its health department. In 1979 he was appointed county coordinator and subsequently director of its consolidated human services programs. He also has been employed at the Division of Health as an epidemiologist and disease control consultant to local health departments. He holds a Bachelor of Science degree in biology from St Norbert College and a Master's degree in public health from the University of Minnesota.

A member of the State Health Policy Council's Committee on Environmental Health, Rentmeester also is a former member of the Legislative Council Committee on Environmental Health.

DIVISION OF COMMUNITY SERVICES

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(listed by district and serving the counties therein)

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District 3: **Lake Winnebago Area Health Systems Agency, Inc (LWAHSA)** 424 Washington Ave, Suite 201, Oshkosh, Wisconsin 54901
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Dennis Riker, Executive Director (Ph 414/432-5284)
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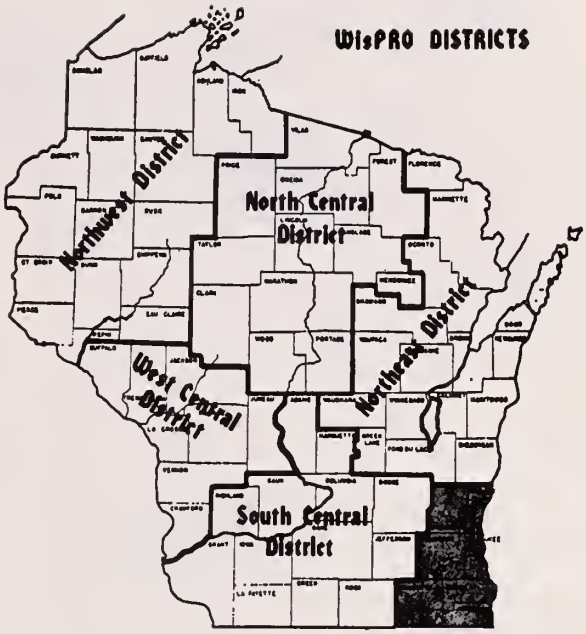

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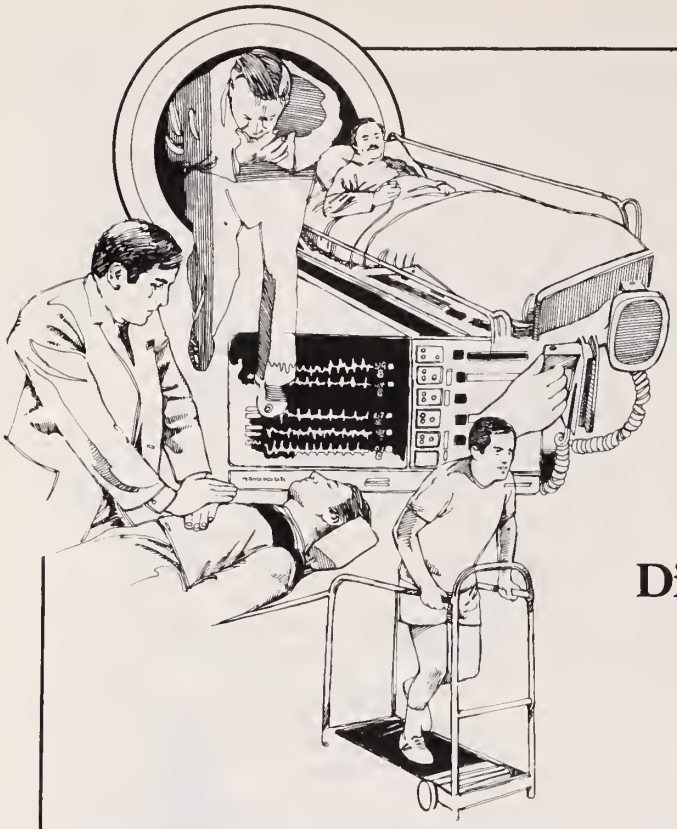
1. Advertisement should not be false, deceptive or misleading nor make use of sweeping superlatives.
2. Unfair comparisons and disparagment of a competitor's goods will not be allowed.
3. When excerpts from a published paper are included in advertising copy, the Bureau may require the advertiser or his agent to obtain written permission from the author and from the editor or publisher of the publication in which the paper appeared.
4. Advertising copy will not be accepted if, in the opinion of the Bureau or the management of the medical journal, the copy (a) appears to violate the Principles of Medical Ethics of the American Medical Association or of a state medical association, (b) is indecent or offensive in any way, (c) contains attacks of a personal, racial or religious character, or (d) appears to be contrary to any regulation or law for the prevention of discrimination, or (e) contains claims found by any court or federal or state agency to be invalid or in violation of law.
5. Advertisers and advertising agencies agree to protect and indemnify both bureau and any medical journal represented by Bureau against any and all liability, loss or expense arising from claims for libel, unfair competition, unfair trade practice, infringement of trademarks, trade names or patents, copyrights or proprietary rights, violations of rights of privacy and any other claims resulting from any advertisement submitted to the Bureau or published in any such medical journal.

The foregoing principles may be changed at any time without notice.

"Bureau" as used above refers to the State Medical Journal Advertising Bureau, Inc., Oak Park, Illinois.



ANNOUNCING

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SUMMARY REPORT, HOUSE OF DELEGATES

State Medical Society of Wisconsin, March 26-28, 1981

THE FOLLOWING constitutes the summary report of actions taken at the Annual Meeting of the House of Delegates, March 26-28, 1981, in Milwaukee. Resolutions and reports were widely distributed to delegates, alternates, county society officers, and others. Members of the Society may, upon request, study the official transcript of the meeting at the State Medical Society headquarters in Madison, or inquire as to the full content of a particular report or resolution.

Earl R Thayer
Secretary

THE HOUSE DELIBERATED 26 resolutions as well as reports of officers, the Council, commissions, committees, and ad hoc committees, including a general revision of the Constitution and Bylaws introduced at the 1980 meeting. Refer to the February 1981 *Wisconsin Medical Journal* for abstracts of resolutions 1 through 20 and their sources. Following is the text of the House of Delegates reference committee reports (with additional commentary inserted where needed for meaning) and indication of House action upon their recommendations.

REFERENCE COMMITTEE ON REVISION OF THE CONSTITUTION AND BYLAWS

SPECIAL NOTE: The revised Constitution and Bylaws as adopted at this meeting appear elsewhere in this June 1981 *Wisconsin Medical Journal* "Blue Book" issue. Below are actions taken by the House on recommendations of the reference committee by which the document introduced in 1980 was amended:

Constitution

- *Article II* was amended by addition of the following sentence: "As used in the Constitution or Bylaws, 'physician' means a doctor of medicine or a doctor of osteopathy licensed in Wisconsin."
- *Article IV* was amended by deletion of the words "who shall also be members of the American Medical Association;" thereby terminating the unified membership requirement. For the record, a roll call vote to approve this deletion at the second session on March 27 was 92-49, or two short of the 2/3 majority required. A motion to reconsider passed after the House reconvened on March 28, and the deletion was then adopted by a vote of 109-9.
- *Article V* was amended by addition to paragraph two, "except that if they have been duly seated as delegates, they shall have the right to vote."
- *Article VIII* was amended to restore prior Section 2: "The place for holding each Annual Meeting shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Board. The time for holding each Annual Meeting shall be approved by the Board."
- *Article IX* was amended to provide that the Society treasurer, formerly elected by the Board, shall be elected by the House of Delegates.
- *Article X* was amended to change the word "equally" to "equitably" in reference to the application of dues by class of members.
- Through its action to terminate unified membership, the House in effect adopted Resolution 1 introduced by Columbia-Marquette-Adams, and rejected Resolution 2 by LaCrosse County Medical Society which introduced the same proposed result for action in 1982.

Bylaws

- *Chapter I, Sec. 3* was amended to delete the word "reputable."
- *Chapter III, Sec. 3,* amended to include election of the treasurer by the House of Delegates.
- *Chapter X, Sec. 4,* amended to provide that each county medical society shall elect one or more delegates "and may elect an equal number of alternates to substitute for any absent delegates from that component society."
- *Chapter XII* amended to delete Sec. 2 as redundant. See also actions on the report of the Reference Committee on Finances which include several additional Bylaw amendments.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

- **Report of President Lewis.** The committee recommends adoption and encourages study of its recommendations for future activity by the Society; and wishes to express appreciation for Doctor Lewis' leadership during the past year.
  Action: Adopted and printed in May issue
- **Report of President-elect Motzel.** The committee recommends adoption.
  Action: Adopted and printed in May issue

- **Report of Secretary Thayer.** Report S outlines management strategies for the implementation of the Society's goals and objectives; adoption recommended.

  Action: Adopted

- **Council Report R,** excepting parts B, C and E, was considered by the committee; adoption recommended.

  Action: Adopted, including the report on 1980 House of Delegates actions and recommendation that the 1985 Annual Meeting be held in La Crosse

- **Council Supplementary Report sections A and G** relating to a proposed Medicaid reimbursement update to existing T-19 contracts and discussing WHCLIP premium reductions and refunds were considered; adoption recommended.

  Action: Adopted

- **Resolution 6** encourages presidents of county societies to serve one year in the capacity of president-elect to gain the experience to effectively assume the responsibilities of president; adoption recommended.

  Action: Adopted

- **Resolution 7** proposes that the State Medical Society organize a conference directed at providing county medical society officers with practical knowledge to enable them to better serve their local societies; adoption recommended with a revised fiscal note to cover estimated costs of a luncheon at $200-$400, and cost of mailings and materials at $175.

  Action: Adopted

- **Resolutions 8 and 9, T-19 second opinion program.** While the committee approves the resolutions in principle, it sees no need to introduce legislation to repeal the second opinion program in view of the sunset provision. The committee recommends that the Society oppose any attempt to extend the second opinion program beyond the sunset and encourages physicians to educate their local legislators of the ineffectiveness of this program, and rejection of the resolutions.

  Action: Resolution 8 was adopted in the following amended form:

  RESOLVED, That the State Medical Society of Wisconsin urge and support legislation to repeal legislation mandating a second opinion before surgery; and be it further

  RESOLVED, That the State Medical Society oppose any attempt to extend the second opinion program beyond the sunset and encourages physicians to educate their local legislators of the ineffectiveness of this program.

- **Resolution 10** concerns uniform fees. While the committee supports the intent of the resolution, it recommends that it not be adopted, but rather that the House encourage the Physicians Alliance and the Council to take such action as may be necessary to formulate guidelines in the area of developing a fair and reasonable reimbursement system throughout the state as it relates to the request from DHSS on T-19.

  Action: Recommendation adopted, changing the word "encourage" to "authorize and direct."

- **Resolution 12** calls for support of equitable risk classification in medical liability premiums; adoption recommended.

  Action: Adopted

- **Resolution 13** deals with the Society's support of WHCLIP. The reference committee recommends adoption with the following substitute resolves:

  RESOLVED, That the State Medical Society remind its members of the historical facts and caution them to think carefully about transferring their WHCLIP professional liability protection to other carriers; and be it further

  RESOLVED, That the State Medical Society support the principles by which WHCLIP is administered, specifically: (1) in regard to not surcharging or cancelling coverage on the basis of a physician's specialty or past experience, and (2) physician representation on the WHCLIP Board of Governors and committees thereof.

  Action: Adopted

- **Resolution 22** recommends that the House of Delegates rescind its 1977 action that no member serve concurrently as a constitutional officer of the Society and as a delegate or alternate delegate to the American Medical Association.

  Action: Resolution adopted; 1977 action rescinded

- **Resolution 23,** health education in Wisconsin schools K-12. The committee recommends adoption of the resolution which recognizes the importance of health education and encourages county medical societies to emphasize this importance to their local school boards.

  Action: Adopted

- **Resolution 24,** physical education in Wisconsin schools. The reference committee recommends adoption with the following substitute resolve:

  RESOLVED, That the House of Delegates of the State Medical Society of Wisconsin recommend to the schools of Wisconsin that they maintain their efforts to provide appropriate physical education at the K-12 level.

- **Report E, Physicians Alliance Commission,** enumerates the commission's accomplishments and future goals. The reference committee recommends adoption and wishes to give special commendation to the Alliance Commission for its informative Legislative Issues booklet.
  Action: Adopted

- **Report F, Commission on Public Information,** outlines the commission's activities over the past year in effectively communicating the policies and activities of the State Medical Society to the public and its membership; adoption recommended.
  Action: Adopted

- **Report G, *Wisconsin Medical Journal* Editorial Board,** outlines the Board's accomplishments and future goals; adoption recommended.
  Action: Adopted

- **Report K, Committee on Maternal and Child Health,** describes the activities of the committee over the past year; adoption recommended.
  Action: Adopted

- **Report L, Committee on Medicine and Religion,** explains efforts by the committee to meet with clergy to improve communication and cooperation for the benefit of patients; adoption recommended.
  Action: Adopted

- **Report O, Committee on School Health,** outlines its extensive activities over the past year and enumerates future goals; adoption recommended.
  Action: Adopted

REFERENCE COMMITTEE ON NATIONAL ISSUES

- **Resolution 11** deals with the frequency of nursing home physician visitation. The reference committee recommends adoption with the following substitute for the first resolve:
  RESOLVED, That the State Medical Society of Wisconsin support the attending physician visiting his/her patient on a schedule determined by the patient's medical needs and oppose mandatory designation for the number of physician visits to nursing home patients.
  Action: Adopted together with a second resolve "That personal physicians should be strongly encouraged to continue care for their patients admitted to nursing homes if practical and reasonable."

- **Resolution 15** recommends formal endorsement of the concept of cost containment and adoption of 65 specific cost containment suggestions. Your reference committee supports the intent of the resolution but recommends that it be referred to the Cost Containment Committee of the Physicians Alliance Commission with a request that the committee meet on a regular basis and prepare a document on cost containment applicable to all physicians in the state to present to the House of Delegates at the next regular session; also recommends that the authors of this resolution (Brown County Medical Society) have significant input into the deliberations of the Committee on Cost Containment.
  Action: The House adopted a restatement by Brown County of cost containment suggestions for physicians, hospitals, and patients, 29 in number, and included this in the referral to the Cost Containment Committee.

THANK YOU

The reference committees of the House of Delegates are to be commended for their thoughtful deliberations and thanked for a job "well done."

Reports of Officers
Donald E Riemer, MD, Cumberland, *Chairman*
James J Tydrich, MD, Richland Center
Richard W Biek, MD, Milwaukee
Paul M Cunningham, MD, Appleton
Stephen B Webster, MD, LaCrosse

Reports of Standing Committees
David L Nelson, MD, LaCrosse, *Chairman*
Marvin G Parker, MD, Racine
Frederick T Mansell, MD, Green Bay
Michael P Mehr, MD, Marshfield
James D Kramer, MD, Wausau

Revision of the Constitution and Bylaws
Albert J Motzel Jr, MD, Waukesha, *Chairman*
Raymond C Zastrow, MD, Wauwatosa
Russell F Lewis, MD, Marshfield
Pauline M Jackson, MD, LaCrosse
John E Dettmann, MD, Green Bay

Finances
Karl E Walter, MD, Eau Claire, *Chairman*
Dolores A Buchler, MD, Madison
Wayne H Konetzki, MD, Waukesha
Hubert V Moss Jr, MD, Madison
Roger L von Heimburg, MD, Green Bay

National Issues Committee
Robert F Purtell Jr, MD, Milwaukee, *Chairman*
John K Scott, MD, Madison
Kermit L Newcomer, MD, LaCrosse
William L Treacy, MD, Milwaukee
Raymond L Hansen, MD, Marshfield

Duane M Taebel, MD
Speaker

- **Resolution 16** proposes a mandated deductible or coinsurance feature in health insurance policies. Your reference committee recommends adoption with the resolve amended to read "that we, the physicians of Wisconsin, urge that some form of contribution from the ultimate consumer of medical care, such as coinsurance or a deductible, be offered as an optional component of all health insurance policies."
  Action: Adopted

- **Resolution 20** concerns physicians as independent contractors. Your reference committee recommends adoption with a request that staff of the Physicians Alliance investigate the status of Bill S-8 (97th Congress) and report to the AMA delegation for any necessary implementation on the AMA level.
  Action: Adopted

- **Resolution 21** requests a federal study of the validity of chiropractic. Because numerous studies of the validity of chiropractic have been conducted and reported, and because further studies would not be cost effective, your committee recommends rejection of this resolution.
  Action: Resolution rejected

- **Report of Committee in Federal Legislation portion of Report B** of the Commission on Governmental Affairs. The committee was informed that paragraph four should be corrected to read: "committee actions, once reported to and approved by the Commission on Governmental Affairs, are sent to the Council of the State Medical Society and when appropriate, forwarded to the Wisconsin Congressional delegation." The committee recommends acceptance as restated.
  Action: Adopted

Attendance: 1177

Total attendance of the two-day scientific program, March 27-28, 1981 at MECCA in Milwaukee was 1177.

Registration of physician members was 862, 25 nonmember physician registrants, and 11 guest physicians, while the balance consisted of 89 technical exhibitors; 16 scientific exhibitors; 91 interns, residents, and medical students; and 83 guests (certified nurses, physician spouses, and others).

The three sessions of the House of Delegates had the following registrations: 130 first session; 142 second session; and 123 third session. There are 161 voting members of the House.

Credentials Committee
Sandra L Osborn, MD, Madison, *Chairman*
John E Thompson, MD, Nekoosa
Dean D Miller, MD, Milwaukee

- **Report P** outlines the activities of the Jail Health Care Technical Assistance Committee. Your committee supports the project, commends the Jail Health Committee for innovative and effective work in health care delivery, urges the committee to continue to seek alternate sources of funding if federal funding is discontinued, and recommends the report be accepted.
  Action: Adopted

- **Report Q** outlines activities and recommendations of the House of Delegates Ad Hoc Committee on National Issues. Your reference committee recommends addition of the words "when appropriate" to the recommendation to the Council that the leadership of the Society support the American Medical Association, its leaders and its program in the spoken and the written word, and commends the committee for its fine work. It is noted that many of the recommendations already have been implemented by the Council and the Speaker of the House, and the reference committee urges further implementation of the remaining recommendations in the report, and adoption of the report.
  Action: Adopted

- **Report of AMA Delegation.** The reference committee recommends acceptance.
  Action: Adopted

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

- **Resolution 14** recommends that the State Medical Society accumulate information concerning IPA-HMO programs in the State of Wisconsin in order to disseminate material concerning this movement to interested members; adoption recommended with deletion of the second resolve because that language is contained in the first resolve.
  Action: Adopted as amended

- **Resolution 17** encourages the Wisconsin Legislature to reenact a mandatory motorcycle helmet law. The reference committee believes the word "mandatory" should be deleted from the resolve clause and the word "motorcycle" should be substituted.
  Action: Adopted as amended

- **Resolution 18** recommends that the Society sponsor legislation mandating loss of freedom for those who are convicted of driving while intoxicated. The reference committee recommends the following substitute resolve: "That the State Medical Society of Wisconsin support legislation that would effectively deal with those who are convicted of driving while intoxicated."
  Action: Adopted as amended (54-53)

- **Resolution 19** recommends that the State Society obtain model legislation to curtail the proliferation of paraphernalia shops and make that legislation available to component county societies. The reference committee recommends the following substitute resolve: "That the State Society obtain model legislation regarding curtailment of drug paraphernalia shops, make it available to component county societies, and that State Medical Society Alliance Field Consultants be requested to assist county societies in enacting appropriate ordinances at the local level.
  Action: Adopted as amended

- **Resolution 26** recommends that the State Medical Society establish a mechanism whereby an individual member's disputes and/or problems may be monitored and appropriate information be in the hands of county officers and/or councilors. The reference committee recommends rejection of this resolution because such a mechanism is already in place.
  Action: Resolution rejected

- **Report A of the Commission on Continuing Medical Education** outlines its activities on accreditation and medical education programming for the past year and its goals for the coming year; adoption recommended.
  Action: Adopted

- **Report B of the Commission on Governmental Affairs** details the many state legislative issues considered by the commission over the past year. The March 26, 1981, Special Annual Meeting Edition of Capitol Week supplements this report. The committee recommends adoption of the portion of Report B specific to the Commission on Governmental Affairs and the Capitol Week supplement.
  Action: Adopted

- **Report C of the Commission on Health Planning** outlines its activities. The reference committee recommends adoption of this report and further recommends astute, continued vigilance in the health planning process.
  Action: Adopted

- **Report D of the Commission on Mediation and Peer Review** outlines the commission's activities. The reference committee recommends adoption and commends the commission for its work with the Medicaid Medical Audit Committee and the Impaired Physician Program.
  Action: Adopted

- **Report H** enumerates the accomplishments and future goals **of the Committee on Aging and Extended Care Facilities;** adoption recommended.
  Action: Adopted

- **Report I** outlines the activities **of the Committee on Alcoholism and Other Drug Abuse;** adoption recommended.
  Action: Adopted

- **Revised Report J of the Committee on Environmental and Occupational Health** outlines several issues which this committee has considered; adoption recommended.
  Action: Adopted

- **Report M** outlines the **Committee on Mental Health** activities and future goals; adoption recommended.
  Action: Adopted

- **Report N of the Committee on Safe Transportation** outlines the activities of the committee and delineates plans for the coming year. The reference committee recommends approval of the report and wishes to commend the committee for its promotional efforts to increase child restraint usage.
  Action: Adopted

- **Supplementary Report of the Council, Item D, Definition of Medical Psychotherapy.** The reference committee recommends approval of the Council report that the Committee on Mental Health will proceed to work on a redefinition of medical psychotherapy which is different from psychotherapy performed by allied health practitioners.
  Action: Adopted

- **Supplementary Report of the Council, item E,** progress report on the work of the **Ad Hoc Committee on Allied Health Practitioners;** adoption recommended.
  Action: Adopted

REFERENCE COMMITTEE ON FINANCES

- **Resolution 3, SMS Dues Structure for Two-Physician Families.** The committee agrees with the intent of the resolve but feels the following substitute would provide for more opportunity to implement the idea:

  RESOLVED, That the Council investigate alternative dues structures which would provide incentives for both physicians in two-physician families to become members. As an example, we have the recommendation by the Council Membership Committee that consideration be given to the reduction of dues by cost of mailing to two members at one home address.

  Action: Substitute adopted

- **Resolutions 4 and 5, SMS Dues for Members Over Age 70.** The committee is sympathetic to the idea of removing some dues for those who have been members for a considerable length of time; however, we feel a total waiver of dues simply by virtue of age is not appropriate at this time. Therefore, as an alternative we propose the following substitute resolve:

  RESOLVED, That Chapter I, Section 9, B of the new Bylaws be amended to add the following: "(8) Over Age 70. Members who are age 70 effective January 1 of the following year"; and that Chapter I, Section 10, B, be amended to read: "Physicians in part-time practice or over age 70: one-half of regular member dues and assessments."

  Action: Bylaw amendments adopted

- **Resolution 25, State Medical Society Past Presidents Dues Waiver.** The reference committee heard only positive testimony on this resolution and heartily endorses it; adoption of Bylaw amendment recommended to add the following words to Chapter I, Section 9, B (6) on Life Members: "or are past presidents of the State Medical Society of Wisconsin."

  Action: Bylaw amendment adopted

ANNUAL MEETING

Scientific exhibit awards

The following scientific exhibits were given Special Merit Awards at the 1981 Annual Meeting of the State Medical Society:

Radiographic Abnormalities of the Patello-femoral Joint, by Myron M Wojtowycz, MD; F A Mann, MD; and William Zweibel, MD, University of Wisconsin Center for Health Sciences, Department of Diagnostic Radiology, Madison.

Lupus Anticoagulant, by Christopher J Drayna, MD; Michael J Sanfelippo, MS; and Michael A Maradik, RBP, Columbia Hospital, Milwaukee.

St Mary's Burn Center Skin Bank, by Ralph M Guttman, MD; D Philip Roberts; and Joseph Perez, St Mary's Hospital, Milwaukee.

Multiple Hereditary Exostosis—A Correlative Study of Radiology, Scintigraphy and Pathology, by Thomas A Lange, MD, University of Wisconsin Center for Health Sciences and William S Middleton Memorial Library, Veterans Administration Hospital, Madison.

Additionally, the Gunnar Gundersen Gold Medallion Award was given to Warren G Smirl, MD, Waukesha, for his exhibit on *Historical Medical Books.*

- **Treasurer's Report and Audit Report.** Our Treasurer, Doctor Edwards, Chairman of the Council Finance Committee, Doctor Foley, and the independent auditor were all present to testify. It is apparent that while the Society is heading in the right direction as far as being a fiscally sound organization and having adequate reserves, the present situation is far from being ideal with having only approximately three months of operating expenses in reserves. The principal reason for these reserves is favorable investment income over the past few years which may not continue. Doctor Edwards pointed out that while the treasurer's report indicates a 1980 excess income over expenses of $138,000, when combined with SMS Realty Corporation and SMS Services, Inc., both wholly owned affiliates of the Society, this figure is reduced to $41,000. This is indicated in the consolidated audit report which also was reviewed. The committee feels that the concept of adding to the reserves be continued, endorses the objective of eventually having six months' operating expenses in reserves, and recommends the treasurer's report and consolidated audit report be received.

  Action: Reports received

- **1981 Budget.** Doctors Foley and Edwards spoke of the various controls on expenditures and the budgetary process used to develop this plan for 1981. Other members present both testified and asked questions that were promptly answered. After consideration in closed session, your committee recommends the 1981 budget be approved as presented.

  Action: Adopted

- **1982 Dues.** This was referred to the committee through the initial and Supplementary Council Reports. We heard testimony both pro and con on the proposed dues increase. In light of comments made earlier in this report on fiscal responsibility, your committee feels the 1982 proposed dues level should be established at $410, which represents a $30 or 8% increase over the current level.

  Action: Adopted

- **Council Supplementary Report, item C, Reduced Dues for New Practitioners.** The committee heartily agrees with the recommendation to eliminate prior membership as a criterion for new practitioners to receive reduced dues and recommends the policy be established as follows:

  "Members who are entering practice for the first time may have reduced SMS and/or AMA dues. A physician who is elected to membership in this State Society within six months of completing residency, fellowship or fulfillment of government obligation enjoys a State Society reduction of 50% the first year and 25% the second year. AMA dues are reduced by 50% for all physicians entering their first year of practice."

  Action: Adopted

- **SMS Services, Inc. Informational Report.** There was testimony on this by a Board member as well as staff. The committee encourages this organization to continue in its efforts to develop supplementary sources of revenue.
  Action: Report received

- **CESF Informational Report.** There was testimony given by the Foundation's President, Doctor Cooney, as well as other members. Concern was expressed both in open and closed session regarding the failure of MDs to repay the student loans received from Foundation funds and the committee encourages all reasonable efforts including use of collection agency and lawyers to obtain repayment of the delinquent accounts.
  Action: Report received

- **Other House Actions:**
  - At the first session on March 26, the House adopted a new standing rule:
    8. The House may adopt, reject or amend a report, or any part thereof, of a Society committee, including the committee which originated such report, or a reference committee which considered and made recommendations with respect to it. In the case of an original committee report, the House may also postpone the consideration of such report to a definite time, or may refer it back to the committee of origin for further study, modification, or recommendations.
  - Elected a Nominating Committee whose membership is published in this issue
  - Elected officers, AMA delegates and alternates, and confirmed the elections of district directors as reported in the April issue■

Recipients of awards presented by the State Medical Society of Wisconsin 1981

COUNCIL AWARD
Joseph M Lubitz, MD, Oconomowoc

HOUGHTON MEDICAL STUDENT AWARD
Douglas Gentile (Medical College of Wisconsin)
Marc Williams (University of Wisconsin Medical School)

ELVEHJEM MEMORIAL LECTURE AWARD
David Sutherland, MD, Minneapolis, Minnesota

BEAUMONT MEMORIAL LECTURE AWARD
Ward O Griffen, MD, Lexington, Kentucky

FIFTY YEAR CLUB AWARDS
See May 1981 issue of *Wisconsin Medical Journal*

GUNNAR GUNDERSEN GOLD MEDALLION AWARD
Warren G Smirl, MD, Waukesha

A complete listing of recipients of awards for the previous years can be found in the June 1979 and June 1980 BLUE BOOK issues of WMJ. Further details of the 1981 awards appear in the May 1981 issue. (Doctor Lubitz died May 15, 1981.)

FINANCIAL STATEMENTS appear on following page

MEDIGAP HOTLINE: 1-800-362-3930

Designed to answer health insurance questions.

- **Health insurance and retirement**
  How will my insurance needs change when I reach 65?
  What is a Medicare Supplement policy?
  How do different policies compare in coverage? In cost?
  What policies are currently on the market?

- **Health insurance for those over 65**
  Do I have good health care coverage?
  Am I paying for too much insurance?
  Can I replace my policy with a better one?

- **Special kinds of health insurance**
  Are cancer policies worthwhile?
  How do indemnity policies work?
  Do I need a nursing home policy?

- **Medical Assistance (Medicaid, M.A., Title XVIX**
  Am I eligible for Medical Assistance?
  Do I need private insurance with M.A.?
  What does M. A. cover?
  Where do I apply?

Medigap Hotline is a project of the Center for Public Representation in Madison. It is available to Wisconsin residents over age 65 or approaching retirement. When the Hotline is not in operation, a recording will give the scheduled times for calling.

THE FOLLOWING FINANCIAL STATEMENTS of the State Medical Society of Wisconsin are part of the Treasurer's Report to the House of Delegates. The Annual Certified Audit, prepared by Bailey, Calmes & Co, certified public accountants, is on file at Society headquarters. Members wishing to review the Audit may do so upon inquiry to the Secretary.

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
General Fund
STATEMENT OF INCOME AND EXPENSE
Year Ended December 31, 1980

INCOME	
Membership Dues	$1,412,411.29
Income From Invested Funds	113,677.03
Annual Meeting Income	38,992.00
AMA Grant for Study of Health Care in Correctional Institutions	32,549.00
AMA Collection Fees	13,003.84
Wisconsin Medical Journal Advertising, Subscriptions and Reprint Income	67,120.63
Mailing Labels	12,417.76
Equipment Rental	8,280.00
Contract Services Furnished Other Organizations	12,208.28
Other Income	15,626.78
TOTAL INCOME	$1,726,286.61
EXPENSES	
Payroll	$715,740.23
Payroll Related Costs	169,723.14
Travel Expense	143,978.64
Telephone Expense	42,287.77
Conference Expense	52,997.24
Postage	33,173.68
Outside Services	21,648.04
Printing and Supplies	140,283.40
General Insurance	10,473.96
Association Dues	4,681.00
Resource Materials	4,604.93
Cafeteria Expense	11,927.16
Grants and Appropriations	10,180.00
Rent	87,571.36
Property Taxes	1,676.73
Repairs and Maintenance	1,250.71
Mail Service	23,674.00
Data Processing Services	29,958.62
Depreciation	17,118.58
Speakers Expense	12,212.21
Legal Counsel	21,084.50
Certified Public Accountant Services	17,273.25
WHCLIP Actuarial Expense	5,000.00
Miscellaneous Expense	8,718.37
Provision for Bad Debts	233.05
TOTAL EXPENSES	1,587,470.57
Excess Income Over Expense	$ 138,816.04

NOTES:

(1) This statement presents only the income and expense of the State Medical Society of Wisconsin (SMS) and is not prepared on a consolidated basis with SMS Realty Corporation or SMS Services, Inc. both totally controlled subsidiaries of the State Medical Society of Wisconsin.

(2) Intercompany transactions between SMS, SMS Realty Corporation, and SMS Services, Inc. have not been eliminated for the preparation of this statement.

STATE MEDICAL SOCIETY OF WISCONSIN
Madison, Wisconsin
General Fund
BALANCE SHEET
December 31, 1980

ASSETS		
Current Assets		
Cash		$ 70,664.65
Accounts Receivable—General	$ 31,681.43	
Less: Reserve for Doubtful Accounts	233.05	31,448.38
Due from Affiliated Organizations		61,582.89
Commercial Paper		670,746.92
Repurchase Agreement		700,000.00
Common Stock—At Cost (Market Value $11,808.00)		8,361.52
Accrued Investment Income Receivable		15,205.44
Employee Travel Advances		3,136.50
Prepaid Expenses		28,873.41
Supplies Inventory		10,104.30
Total Current Assets		$1,600,124.01
Fixed Assets		
Furniture and Equipment	$120,169.70	
Computer Software	20,581.50	
Subtotal	$140,751.20	
Less: Accumulated Depreciation	87,215.78	
Total Fixed Assets		53,535.42
Other Assets		
Investment in SMS Services, Inc.	$51,299.42	
Long Term Loan to SMS Realty Corp.	70,000.00	
Total Other Assets		121,299.42
TOTAL ASSETS		$1,774,958.85
LIABILITIES AND NET WORTH		
Current Liabilities		
Accounts Payable		$50,160.77
Dues Held for the Section on Ophthalmology		17,762.11
Dues Payable to the American Medical Association, County Medical Societies and Related Organizations		1,475.50
Accrued Payroll Taxes and Other Payroll Deductions		4,109.05
Accrued Property Taxes		1,676.73
Journal Advertising Commissions Payable		358.92
Sales Tax Payable		78.82
Accrued Payroll and Vacation Pay		47,411.44
Unapplied Membership Dues		2,641.50
Accrued Miscellaneous Expense		141.75
Deferred Income:		
Prepaid Annual Meeting Income	$ 13,050.00	
Prepaid Membership Dues	1,271,253.17	1,284,303.17
Total Current Liabilities		$1,410,119.76
NET WORTH		
Surplus, January 1, 1980	$ 253,516.04	
Plus 1980 Income over Expense	138,816.04	
Subtotal	$ 392,332.08	
Less: Decrease in Value of Investment in SMS Services, Inc.	27,492.99	
Total Surplus December 31, 1980		364,839.09
TOTAL LIABILITIES AND NET WORTH		$1,774,958.85

NEW DIRECTORS PICTURES APPEAR ELSEWHERE IN THIS ISSUE

District 1

Jerome W Fons Jr, MD, Cudahy

Born in Milwaukee, Wisconsin on February 14, 1932, Doctor Fons is a 1962 graduate of Marquette University School of Medicine. He served his internship and residency at St Joseph's Hospital in Milwaukee from 1962 to 1966 and in 1963 he received his license to practice medicine in Wisconsin. During 1954-55, he served in the US Army Medical Corps in Alaska. An obstetrician-gynecologist, Doctor Fons is on the medical staff of Trinity Memorial Hospital and has served as an instructor at the Medical College of Wisconsin. A member of the State Medical Society since 1964, he is married and has six children. Doctor Fons was elected to the Board of Directors in March 1981 to fill the unexpired term of Paul C LaBissoniere, MD, Milwaukee, who resigned.

District 1

Wayne H Konetzki, MD, Waukesha

Born August 2, 1936 in Chicago, Illinois, Doctor Konetzki graduated from University of Illinois Medical School in 1961. An internist, he served his internship at Presbyterian-St Luke's Hospital in Chicago, Illinois from 1961-1962 and his residency at Milwaukee County General Hospital from 1962-1965. Licensed to practice medicine in Wisconsin in 1962, from 1965-1967 Doctor Konetzki served as a captian in the US Air Force. An active member of the State Medical Society since 1967, Doctor Konetzki was elected to the Board of Directors in March 1981, for a three-year term, succeeding John J Foley, MD, Menomonee Falls.

District 1

William L Treacy, MD, Milwaukee

Born on September 23, 1932 in Milwaukee, Wisconsin, Doctor Treacy graduated from Marquette University School of Medicine in 1957. An internist, he served his internship at St Joseph's Hospital from 1957-58 in St Paul, Minnesota and his residency from 1958-1961 at the Mayo Clinic in Rochester, Minnesota. Licensed to practice medicine in Wisconsin in 1959, Doctor Treacy is a past president of the Wisconsin Society of Internal Medicine and a former chairman of the Department of Internal Medicine at St Joseph's Hospital in Milwaukee. He has been an active member of organized medicine since 1961, serving as a District 1 Delegate to the State Medical Society from 1976-1980. Currently he is a member of the SMS Medical Liability Committee. Doctor Treacy was elected to the Board of Directors in March 1981 to fill an additional position for District 1.

District 1

Fredrick Wood Jr, MD, Kenosha

Doctor Wood was born on March 14, 1924 in Indiana, Pennsylvania. After graduating from Northwestern University Medical School in 1951, he interned at St Luke's Hospital in Chicago, Illinois and also served his residency there, specializing in internal medicine. In 1956 Doctor Wood was licensed to practice medicine in Wisconsin and he served in the US Army from 1943 to 1946 and in the US Air Force reserves in 1953. A member of the medical staffs of Kenosha County and St Catherine's Hospital in Kenosha, Doctor Wood has been a member of the State Medical Society since 1956. He was elected to the Board of Directors in March 1981 succeeding Elizabeth Steffen, MD, Racine, for a three-year term.

District 2

James J Tydrich, MD, Richland Center

Doctor Tydrich was born in Bloom City, Wisconsin on August 24, 1936 and graduated from the University of Wisconsin Medical School in 1962. A family physician, he served an internship at St Luke's Hospital in Duluth, Minnesota from 1962-63. Doctor Tydrich was licensed to practice medicine in Wisconsin in 1963 and is a member of the Richland Center Hospital Medical staff. A member of the State Medical Society since 1963, Doctor Tydrich is also a member of the American Academy of Family Physicians and served on the SMS Committee on Cancer from 1971-1974. He was elected to the Board of Directors in March 1981 to fill the unexpired term of Gerald C Kempthorne, MD, Spring Green, who resigned to become president-elect of the Society.

District 5

Darold A Treffert, MD, Fond du Lac

Born in Fond du Lac, Wisconsin in 1933, Doctor Treffert graduated from the University of Wisconsin Medical School in 1958. After interning at Sacred Heart Hospital in Eugene, Oregon from 1958-1959, he served a residency in psychiatry at University Hospitals in Madison. Formerly director of the Winnebago Mental Health Institute, Doctor Treffert presently is director of the Fond du Lac County Mental Health Center in Fond du Lac. Long active in State Medical Society affairs, he is a past president of the society and was elected chairman of the Board of Directors in 1980 and reelected in 1981. A fellow of the American Psychiatric Association and American College of Psychiatrists, Doctor Treffert was elected to the Board in March 1981 succeeding John U Peters, MD, Fond du Lac, for a three-year term. ■

CES FOUNDATION
CONTRIBUTIONS—MARCH 1981

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for March 1981.

Unrestricted

E D Sorenson, MD; Timothy T Flaherty, MD; SMS Members—*Voluntary Contributions*

Restricted

Brown County Medical Society Auxiliary—*Brown County Loan Fund*

American Family Insurance Co—*Medical Student Summer Externship Program*

CES Foundation—*Museum of Medical Progress*

LaVerne Bartel; Bernard Bartel—*Aesculapian Society Dues*

Mrs Bernard Oleson; Suresh & Georgine Bapat; E C Glenn, MD; William Thomas Jr; Mrs Fred Saeger; Leland G Scanlan; Donald J McCutcheon; William & Anita Maurer; Russell F Lewis, MD; T O Norris; Edna R Berard; Mr-Mrs Lee Richards; Dean W Nelson; Fabian Schrank; Elsie Podawiltz; Dr-Mrs Charles C Sorensen; Mrs Carol P Buehler; Mrs Margaret Grube; Mr-Mrs J Peter Hamel; Dr-Mrs Charles Conger; Andrew Hulme; William Allen; Byron & Evelyn Conway; Mr-Mrs John Brauer; William & Flora Schereck; Calvin E Hagen; Martha Pomainville; Robert M Heywood, MD; Henry & Ann Ashbeck; Michael P Mehr, MD; Dorothy Lichty; Maurice & Jennifer Rice Jr; George & Sue Enwright; Emily Baldwin Bell; Dr-Mrs Arthur Hayward; Ann Pomainville Hacker & Lee; Dr-Mrs Jung K Park; John Thompson; Mrs G A Getzin; Mrs Dwight H Teas; Marion B Fey; Mrs B C Brazeau; George H Handy, MD; Chester Korbol; Mr-Mrs Charles R Lester; Mrs John Alexander; John C Whitman, MD; Wood County National Bank-Wisconsin Rapids—*L C Pomainville, MD Fund*

Memorials

Dr-Mrs Thomas W Tormey Jr; Mr-Mrs F C Dettloff—*John T Sprague, MD (Tormey Medallion Fund)*

Dr-Mrs Robert T Schmidt—*Mrs Goldie Moglowsky; Mrs Orville Myers (Brown County Loan Fund)*

Dr-Mrs Loren E Hart—*Mrs Orville Myers (Brown County Loan Fund)*

Mrs C H Crownhart—*John T Sprague, MD (Crownhart Memorial Fund)*

Medical Staff St Marys Hospital, Madison—*Walter Lappley, MD (Student Loan Fund)*

Dane County Medical Society; Robert B Murphy; State Medical Society—*John T Sprague, MD*

M Elnora Hayes Johnson—*Alvina Bollen*

Dr-Mrs Gerald C Kempthorne—*John Rouse, MD*

State Medical Society—*William A Taylor, MD*■

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- **Charitable assistance**
- **Medical student externship program**
- **Research activity**
- **Continuing medical education**

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CES FOUNDATION
CONTRIBUTIONS—FEBRUARY 1981

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for February 1981.

Unrestricted

Jefferson County Medical Society Auxiliary; Grant County Medical Society Auxiliary; Dane County Medical Society Auxiliary; Fond du Lac County Medical Society Auxiliary; LaCrosse County Medical Society Auxiliary; Edwin L Bemis, MD; SMS Members-*Voluntary Contributions*

Restricted

CES Foundation—*Museum of Medical Progress*

Memorials

Dr-Mrs Robert T Schmidt; Dr-Mrs Loren Hart; Dr-Mrs Herbert F Sandmire—*Dr Brian Goodrich (Brown County Student Loan Fund)*

Mr-Mrs HB Maroney—*Jerry Dyer (Barbara Scott Maroney Memorial Account)*

Joan Esser Janssen—*Eugene Daleiden*

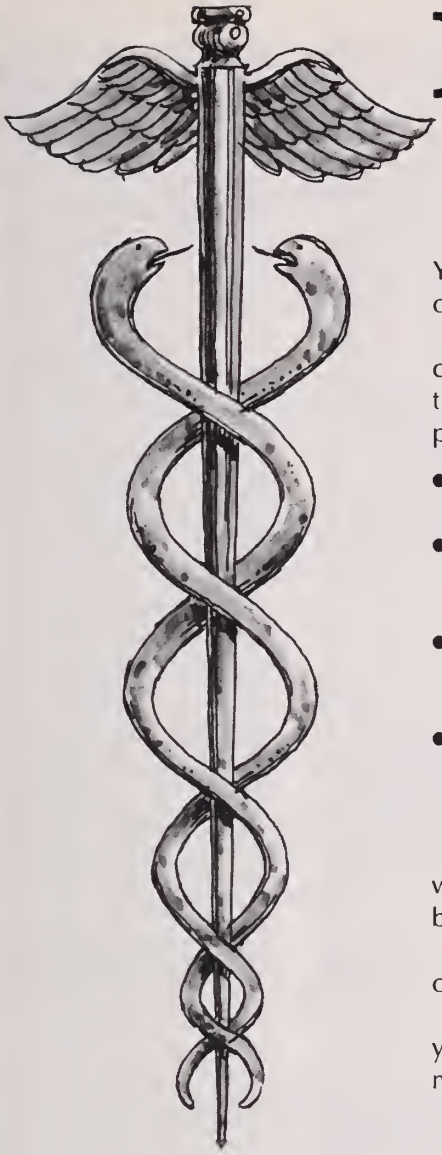
Dr-Mrs Wm C Janssen—*Tim Kulfan*

Dane County Medical Society Auxiliary—*Elsie Wright*

EJ Nordby, MD; Farrell F Golden, MD—*William A Taylor, MD*

Dr-Mrs EJ Nordby; Mr-Mrs Earl R Thayer; Nels A Hill, MD—*John T Sprague, MD*

State Medical Society—*Marvin Wright, MD; William W Grover, MD; Edward D Wilkinson, MD; Paul B Goodman, MD; Thomas C Norris, MD; Donald S Thatcher, MD; Harry H Heiden, MD*



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MEMBERSHIP FACTS

ARE YOU A MEMBER of the State Medical Society of Wisconsin, or do you know someone who isn't? Whether you're just starting medical school, maintain a full-time practice, or are retired, SMS has a membership classification to fit your individual needs. Furthermore, in light of a recent change in membership policy, physicians may join their county, state, and national societies or just their county and state societies. Dues for regular membership are: $380 for SMS, $250 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF DUES CLASSIFICATION CODES

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of illness or financial hardship. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held continuous membership in the State Medical Society for 50 consecutive years or more and all Past Presidents of SMS.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: Member who is engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy.

Emeritus: Retired members who have chosen not to renew their license.

1981 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$380	$250	Normal County Dues
Resident	38	35	Varies
Military Service	-0-	250 or 35	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-	-0-
Honorary	-0-	-0-	-0-
Retired	-0-	-0-	-0-
Part-time Practice	190	250	Normal County Dues
Over Age 70	190	-0-	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-	
Candidate—			
Freshman Year Medical Student	-0-	15	?
Sophomore and Succeeding Medical Student Years	10	15	
Postgraduate—One	10	35	

Developmental disability—autism, informational materials available

Informational materials on the developmental disability—autism—have been developed by the State Division of Community Services Education/Information Section with funds provided by the Wisconsin Council on Developmental Disabilities. These materials include:

- ***The Puzzle of Autism.*** A brochure describing the syndrome of autism. For general audiences.
- ***Autism.*** A Guide for Parents, Professionals and Others. An expanded version of the brochure with special information for parents, teachers, physicians.
- ***Definition of the Syndrome of Autism.*** This approved definition was developed by the National Society for Autistic Children and is useful for parents and professionals.
- ***Autism Bibliography.*** A listing of books and other materials available on the subject of autism from the Central Wisconsin Center Library Information Center.

Copies of these materials have been distributed to libraries throughout the state. Additional copies may be ordered from the Education/Information Section, Room 561, I West Wilson St, Madison, Wis 53702; phone 608/266-0979.

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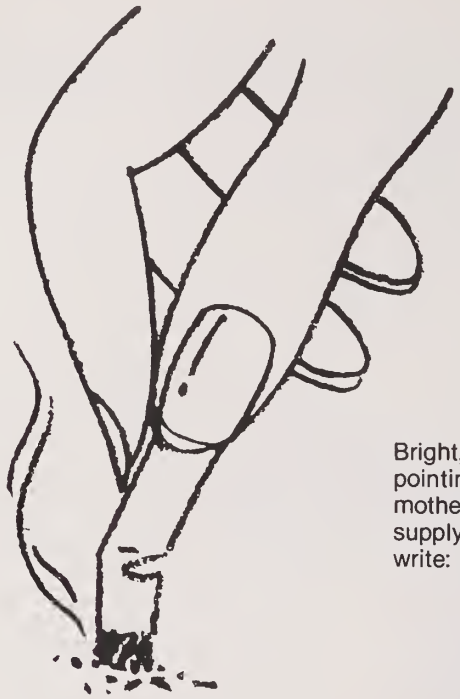

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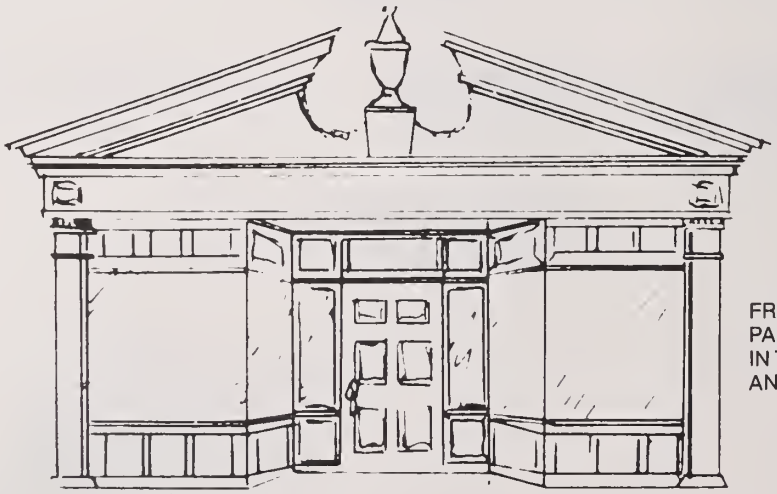

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LET THESE GUIDES HELP YOU

THE FOLLOWING GUIDES and manuals have been prepared or obtained at the direction of the Board of Directors and/or commissions and committees of the State Medical Society of Wisconsin to be of direct personal assistance to the physician or his county medical society. Each is available (some without cost, others at nominal cost) upon request to the Communications Dept., State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

- **Interprofessional Code (1977 Revision)**—An instrument for better understanding between attorneys and physicians with reference to medical testimony and interprofessional conduct and practices.
- **Communications Guide for Wisconsin Hospitals and Physicians**—Establishes a communications guide for Wisconsin hospitals and physicians to promote cooperation between the allied medical professions and those who report medical news.
- **Comments on Fee Splitting Statute, Including Chapter 82, Laws of Wisconsin, 1973**—Governing physicians and others and authorizing employment of physicians by hospitals and others.
- **Approved Program in Continuing Medical Education**—Explains the State Medical Society of Wisconsin's accreditation program for continuing medical education in conjunction with the American Medical Association's Council on Medical Education.
- **Physician Guidelines: Blood-Alcohol Testing**—Includes a request/consent form for drawing blood. (Revised 1978—Single copy 25¢ with order.)
- **If You Have a Complaint About Medical Care**—Medical care is a personal matter between patient and physician. Yet, sometimes misunderstandings arise about what the physician hopes to accomplish and what the patient expects. This brochure, aimed at patients, explains the State Medical Society's grievance and peer review system.
- **School Health Examination**—A guide for physicians and school authorities in establishing a program of school health examinations. (Single copy $1.00 with order.)
- **Occupational Health Guide**—For medical and nursing personnel. A practical manual covering everything from "abnormal injuries" to "wounds," with every item suggesting steps to be taken, and providing space for specific instructions of the plant physician. Over 70 pages of instructional material, with all sections provided as separate sheets, punched to fit a ring book 10"x11½". For handy reference order ring book, with full set of inserts, including anatomical charts. (Complete guide including ring binder: $11.00; complete guide without binder: $10.00—to accompany order.)
- **Make Yours a Smokeless Pregnancy**—Points out the dangers of smoking during pregnancy and its effects on the fetus.
- **Guide to the Service Corporation Law**
- **Retention and inspection of patients' records**—Explains the right of access to physician and hospital records concerning patient care, and includes the revised form, through statute amendment, of an *Interpretation* of Chapter 301, Laws of 1959.
- **Legal Responsibilities of the Physician-Patient Relationship**
- **Report of the Chiropractic Study Committee to the Governor's Health Planning and Policy Task Force**—Recommendations in this report were adopted by the Governor's Health Planning and Policy Task Force, October 23, 1972.
- **A Scientific Test of the Chiropractic Theory**—The first experimental study of the basis of the theory demonstrates that it is erroneous. Written by Edmund S. Crelin and reprinted by permission of *American Scientist.*
- **Some Straight 'Dope' on Marijuana**—Increasing evidence appearing regularly that marijuana is hazardous to health has led the State Medical Society of Wisconsin to declare it to be a dangerous drug. This brochure explains what marijuana is, who uses it, and points out some of the psychological and physiological hazards associated with its use.
- **Rubella—Red Measles Brochure**—This conveniently sized 2½"x4" sized brochure alerts women to the necessity of being immunized for Rubella before they become pregnant. The brochure also reminds parents to have their children immunized for the red measles. Perfect for patient billing statements or waiting rooms.
- **To Your Good Health**—Explains the reasons behind rising health care costs and offers tips on how to save money on medical expenses.
- **Alcohol and Your Unborn Baby . . .**—Warns women of the harmful effects alcohol can have on an unborn child. Available in both English and Spanish versions.
- **To All My Patients, Partners in Good Health**—Explains the rights and responsibilities physicians and patients have in medical care. Available in standard brochure or smaller "statement stuffer" form.
- **I Want To Know What You Think**—a questionnaire physicians can use with patients to elicit their attitudes and opinions regarding his/her medical practice.
- **So You've Been Sued . . . Now What?**—a brochure prepared by the SMS Medical Liability Committee which answers 12 questions physicians commonly ask about medical malpractice lawsuits.

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QUAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences National Research Council and or other information, FDA has classified the indications as follows
"Possibly" effective for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache
Final classification of the less-than-effective indications requires further investigation
The effectiveness of Equagesic in long-term use, i e more than four months, has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient

ONTRAINDICATIONS: Equagesic should not be given to dividuals with a history of sensitivity or severe intolerance aspirin, meprobamate, or ethoheptazine citrate

ARNINGS: Careful supervision of dose and amounts prenbed for patients is advised especially with those patients th known propensity for taking excessive quantities of drugs cessive and prolonged use in susceptible persons, e g , coholics, former addicts and other severe psychoneurot-, has been reported to result in dependence on or habithon to the drug Where excessive dosage has continued weeks or months, dosage should be reduced gradually her than abruptly stopped, since withdrawal of a "crutch" ay precipitate withdrawal reaction of greater proportions an that for which the drug was originally prescribed Abrupt continuance of doses in excess of the recommended dose s resulted in some cases in the occurrence of epileptiform izures
ecial care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultl slowing of reaction time and impairment of judgment and ordination
GAGE IN PREGNANCY AND LACTATION. An increased k of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered
Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery
Suicidal attempts with meprobamate have resulted in coma shock vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants, e g caffeine Metrazol or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses peripheral edema and fever have also been reported
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells angioneurotic edema bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported most of these returned to normal without discontinuation of the drug
Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery However, on the basis of pharmacological data it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, PA 19101

Down with pain

Step up to reliable relief

for mild to moderate pain

Wygesic®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine s although quantitatively less and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e g driving a car or operating machinery Patients should be cautioned accordingly
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation nausea, and vomiting These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria dysphoria, and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion, anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine
MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill, however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered preferably I V ,simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions
Oxygen, IV fluids vasopressors and other suppo tive measures should be used as indicated Gastr lavage may be helpful Activated charcoal can al sorb a significant amount of ingested propoxyphen Dialysis is of little value in poisoning by propox phene alone Acetaminophen is rapidly absorbe and efforts to remove the drug from the body shou not be delayed Copious gastric lavage and or indu tion of emesis may be indicated Activated charco is probably ineffective unless administered almo immediately after acetaminophen ingestion Neith forced diuresis nor hemodialysis appears to be e fective in removing acetaminophen Since acetan nophen in overdose may have an antidiuretic effe and may produce renal damage, administration fluids should be carefully monitored to avoid ove load It has been reported that mercaptamine (cy teamine) or other thiol compounds may protect agai liver damage if given soon after overdosage (8 hours) N-acetylcysteine is under investigation as less toxic alternative to mercaptamine, which m cause anorexia, nausea, vomiting, and drowsines Appropriate literature should be consulted for furth information (JAMA 237 2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity m be delayed up to one week Acetaminophen plasr levels and half-life may be useful in assessing t likelihood of hepatotoxicity Serial hepatic enzyr determinations are also recommended

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Medical Yellow Pages

RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

Emergency Medicine. Directorship and clinical positions in low volume emergency department located in the northwestern portion of Wisconsin. Excellent income with additional compensation for director's responsibilities. Paid professional liability insurance, flexible scheduling without on-call involvement. For details contact Frank Siano toll-free at 1/800/325-3982, or send credentials in complete confidence to 970 Executive Parkway, St Louis, MO 63141. 4-6/81

Wanted. Family Physician to associate with four family physicians and two general surgeons to work in a satellite clinic 12 miles from Fond du Lac, Wis. Fond du Lac is a community of 37,000 located on Lake Winnebago in the heart of Wisconsin's agricultural and recreational area, 60 miles from Milwaukee, Green Bay, and Madison. Rotation of night and weekend call with four family physicians with two month vacation and study per year. 300-bed hospital. Excellent schools, four year liberal arts college, two year University of Wisconsin extension. Contact: John U Peters, MD, 505 East Division St, Fond du Lac, Wis 54935. Call collect: 414/922-3700 (business phone); 414/922-7899 (home phone). 6-8/81

Opportunity for Psychiatrist. Board eligible or board certified psychiatrist to join 50-man multispecialty practice in Southern Wisconsin. Close to University Centers. Competitive income. Contact R E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566, or telephone 608/328-7000. 6-7/81

Full-time medical director needed for busy plasmapheresis center. Excellent pay and benefits. Ideal for retired or semi-retired persons. Inquire Associated Bioscience of Madison, Inc, 515 N Lake St, Madison, Wis 53703. Ph 608/258-8288. 6-8/81

Family Physician wanted to develop solo practice with possibility of association with medical group. Clinton, Wisconsin, a progressive and prosperous farm area. Will provide financial assistance with first-year guarantee income negotiable. May build or rent office. 256-bed hospital affiliation located within 10 miles. Ideal family-oriented community with excellent schools, economy, and recreation. Easy access to Chicago, Milwaukee, Madison, and Rockford. Other doctors available for backup/vacations. Contact S Rudolph, Beloit Memorial Hospital, 1969 West Hart Rd, Beloit, Wis 53511; 608/364-5104. 6-8/81

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Wanted. Partner for partner, generalist-internist for internist-surgeon team. Surgeon will give up general practice but remain on call. Clinic, small hospital combination, no OB. Rural setting, 15 miles from larger city. Phone 608/854-2231. 5-7/81

Duke trained general psychiatrist with strong interest in psychotherapy wishes to relocate in midwest (Wisconsin). Board certified. Contact James L Gallagher, MD, 2219 Mont Haven Dr, Durham, NC 27712. Phone 919/383-4477 (home); 919/417-3487 (office). 5-7/81

Emergency Medicine Opportunities. Directorship and clinical positions available in the greater Milwaukee area. Excellent income, paid malpractice insurance, and flexible scheduling provided. For details, send credentials in confidence to Michelle Grimm, 970 Executive Parkway, St Louis, MO 63141; or call toll-free 1/800-325-3982. 5-8/81

Board certified or eligible family practitioners, OB-GYN and surgeon wanted to join expanding multispecialty group located in South Central Wisconsin near major metropolitan area. Excellent salary structure and benefits first year with options thereafter. Interested physicians inquire immediately. All requests to be answered immediately and in confidence. Write Dept 488 in care of the Journal. 5tfn/81

Initial practice or relocation possibilities in central Wisconsin for independent gastroenterologists and pediatricians. Facilities available in new professional building located across from major medical complex. Personally tailored finished space. Support from established physicians. Contact: Wergin Realty, Inc, 2800 Westhill Dr, Wausau 54401. Phone: 715/848-1344. 5-8/81

Opportunity for Ophthalmologist. Board eligible or board certified ophthalmologist to join 49-man multispecialty practice in southern Wisconsin. Close to University Centers. Competitive income. Contact R E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566 or phone 608/328-7000. 5-6/81

Wisconsin—26 physician incorporated multispecialty group on the south shore of Lake Winnebago needs a fourth pediatrician. Guaranteed salary with full shareholder status available after one year. Send CV to Kirk A Veit, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. p5-7/81

Internist wanted to join a 14-physician multispecialty group in one of northern Wisconsin's finest recreation areas. Modern 109-bed hospital. Excellent professional and personal opportunity. Contact Dr J Wiesner, Lakeland Medical Associates Ltd, Box 549, Woodruff, Wis 54568 or call 715/356-3292. 5tfn/81

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

8-12/80,1-7/81

Physicians Exchange

continued

Ideal Practice Opportunities for:

- Ophthalmologist
- Neurologist
- Psychiatrist
- Urologist
- Family Practice

Board eligible or board certified to join 49-man multispecialty practice in Southern Wisconsin, 45 minutes to Madison and 90 minutes to Milwaukee. Perfect location for good family living. Contact R E Hassler, MD, The Monroe Clinic, Monroe, WI 53566 or phone collect 608/328-7000. 4-6/81

Wisconsin, Oshkosh. Career emergency physician with residency training and/or experience as emergency physician. Well-established, fee-for-service corporation. Active community hospital with brand new physical facilities. Only hospital in town of 55,000. Excellent staff backup, paramedic program telemetry. Flexible scheduling, competitive salary. Fringes: funded CME, generous health and disability insurance allowance, corporate-paid retirement plan, one month vacation, paid malpractice. ACLS certification required. Send complete CVA: T M Loescher, MD, 2520 Crestview Dr, Appleton, Wis 54911. 5-6/81

Wanted Internist or Family Practitioner to share space in new office building with pediatrician in Madison area. Contact Mike McCann, MD, phone 608/831-7170. 5-6/81

Fifty-physician multispecialty clinic in West Central Wisconsin wants allergist, cardiologist (noninvasive), neonatologist, orthopedic surgeon, otolaryngologist, and family practitioner for nearby satellite office. Excellent cultural, educational, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepson, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54701 or phone 715/839-5266. 4-6/81

Family Physician to join two Board certified family physicians and one physician's assistant in a young and growing medical practice in Central Minnesota. The practice is oriented towards family medicine. The practice is located centrally in the state with quick access to Minneapolis/St Paul. Cultural and recreational activities are in abundance in this area of Minnesota. Salary open: Contact Daryl G Mathews, Admin, or Thomas J Newton, MD at the Cold Spring Medical Clinic, 26 N Red River Ave, Cold Spring, Minn 56320. Phone 612/685-8641. 4-6/81

Two Family Practice Physicians sought to assume a fully operational practice in a community 30 miles north of Madison, Wisconsin. New clinic facility. Income guaranteed. Physician back-up available. Board certified or eligible preferred. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 5tfn/81

Wanted. Primary Care Physicians interested in full or part-time employment with the Department of Health and Social Services, Division of Health. Assisted by excellent nursing staff, these physicians will render quality health care to adults and juvenile residents of Wisconsin Correctional Institutions throughout the state. Currently full-time and part-time openings with Waupun, Green Bay, and Kettle Moraine Correctional Institutions. Pay between $42,146 and $64,500 per year, for full-time employment, depending upon previous experience and training. Excellent fringe benefits. Malpractice insurance paid. For more information contact Dr Michael MacLean, Medical Director, 110 E Main St, Room 416, Madison, Wis 53703 or call 608/266-5718. An Equal Opportunity Employe functioning Under An Affirmative Action Plan. 6/81

Racine Medical Clinic, multispecialty group of 22 physicians has a practice association for internist. The clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406. Phone 414/886-5000. 5tfn/81

Wanted. Board certified or eligible oncologist to practice in conjunction with an 8-member medical department in a 22-member multispecialty group. Present sub-specialties: gastroenterology and cardiology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Family Practitioners for Rural Practice. One, but preferably two, family practitioner needed to serve an area of approximately 8,000 in Central Wisconsin. Clinic affiliation or private practice available. Salary guarantee possible. Close to excellent 181-bed fully accredited hospital. Send CV or contact Anton Omernik, Chairman, Recruiting Committee, 46 County A, Rosholt, Wis 54473. Phone 715/677-4761. p4-6/81

The Nicolet Clinic, SC, a young progressive 33 physician multispecialty group, has superb opportunities available for the practice of:

- Family Practice
- Thoracic Surgery

Ideal family oriented community in metropolitan area with excellent schools, economy, culture, and recreation for all four seasons. Located on northern Lake Winnebago. First year negotiable salary with option for full membership at nine months. Adjacent to modern regional hospital. Excellent benefits in addition to qualified profit-sharing plan and support for continued medical education. Contact in confidence Curtis C Baltz, MD, Nicolet Clinic, SC, 411 Lincoln St, Neenah, Wis 54956. Phone: 414/727-4244. 3-6/81

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Marshfield Clinic would like to hire locum tenens for anesthesia. Wisconsin license required. Please send curriculum vitae to Sidney E Johnson, MD, Medical Director, Marshfield Clinic, 1000 North Ave, Marshfield, Wis 54449 or call collect at 715/387-5253. 5-6/81

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN

MEDICAL PROFESSIONAL PLACEMENTS

5222 Painted Post Drive
Madison, Wisconsin 53716
(608) 222-2927

Licensed Employment Agency 9tfn/79

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

Family Practice. Physician needed to join three Board certified family practitioners and one general surgeon. New clinic building adjacent to hospital in beautiful northwestern Wisconsin. Call is shared with other family practitioners in community. Contact Jean Chamberlain, Administrator, Spooner Clinic Ltd, 707 Ash, Spooner, Wis 54801. Phone 715/635-2151. 5-7/81

Position now available in the Department of Internal Medicine for physician with subspecialty interest. Fifty-person multispecialty clinic in ideal location in Southern Wisconsin. Contact R E Hassler, MD, The Monroe Clinic, Monroe, WI 53566; ph 608/328-7000. 5-7/81

The Wausau Medical Center, SC, a progressive multispecialty group, is looking for physicians in the following areas of practice:

- Hematology/Oncology
- Family Practice
- Otolaryngology

Beautiful new building adjacent to new hospital which maximizes patient-physician effectiveness and efficiency. First-year salary open; full membership after two years. Liberal fringe benefit package. Metropolitan area of 65,000 adjacent to the finest vacation area in the Midwest. For more information, write John R Allen, MD, Medical Director, Wausau Medical Center, 2727 Plaza Dr, Wausau, Wis 54401; or call collect to 715/847-3223. 3tfn/80

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Orthopedic surgeon wanted to join a primary care/specialty group of 11 physicians in northwestern Wisconsin. Attractive family/recreational area 45 minutes from Twin Cities. Minimum salary guaranteed first year. Contact Tom Halverson, Clinic Manager, St Croix Falls Clinic, Box 739, St Croix Falls, Wis 54024. Phone 715/483-3221. 8tfn/80

FAMILY PRACTICE OR INTERNAL MEDICINE PRACTITIONER—Team Practice in Madison with Staff Model Health Maintenance Organization

Very attractive working environment, predictable hours, close to University of Wisconsin Medical Center. Physician staff compensation package includes excellent salary, pension program, and full benefit coverage. For more information, call *F Manalo, MD, at 608/257-9700,* or send vitae to: *GHC, One South Park St, Madison, Wis 53715.* 4-6/81

Family Practice Physician sought for affluent small town with excellent social, retail, and educational resources. Easy access to year-round outdoor activities and to Chicago and Rockford for social and professional opportunities. For the family man with ambition for a successful practice.

Contact: Harvey Pettry, Administrator
Highland Hospital
1625 S State St
Belvidere, IL 61008
815/547-5441 6-8/81

Family Practice. General Clinic—Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 23-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 2tfn/81

Medical Facilities

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

FOR RENT office space Greater Milwaukee area. 750-1500 sq ft in prestigious 3-year-old medical building located on Northridge Lakes (7400 West Brown Deer Road) only minutes from Northridge. Opportunity for medical group, specialist, or satellite office. Will remodel to suit. Please call area code 414/354-1160. 12tfn/80

Ritter ENT Unit. Includes motorized chair, service unit with air and suction and cautery and air pump. Also sterilizer with cabinet available. Good condition. Reasonable. PO Box 325, Stevens Point, Wis 54481. Phone: 715/341-2020. 2tfn/81

Available immediately. Solo family practice opportunity. Good growth potential in Fitchburg, the most rapidly developing area in Madison. For details contact M Gordon, MD, 2934 Fish Hatchery Rd, Madison, Wis 53713. Phone 608/273-1055. p4-6/81

Medical Office Building. Racine, Wisconsin. Northside, Highway 32, 3343 Douglas Ave. One story building. Lease occupancy available June 1. Off street parking. Phone 414/639-7223 or 414/878-4020 evenings. 6-8/81

Doctor's Office space. All day Tuesday, Thursday, and Saturday; Wednesday, Friday afternoons. Telephone 414/255-2108. 6/81

Real Estate

The Perfect Retreat. Outstanding year-round vacation home nestled on a secluded bay in the midst of the northwoods of Michigan upper peninsula. This custom designed home of rough sawn cedar has 12 ft cathedral ceilings, 3 bedrooms, 2½ baths, 3 fireplaces, sauna, and 50 ft deck overlooking Portage Lakes Torch Bay. The 100-foot lake front property includes adjacent guest house with fireplace, deck, and 2-car garage. 15 minutes from Houghton-Hancock Jet Airport, downhill ski facilities and Lake Superior. Furnished if desired. Call 513/871-7888 or 871-0632 or write Len Koppana, 3565 Bayard Drive, Cincinnati, Ohio 45208. 6-7/81

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1980 through Aug 31, 1981.

WISCONSIN

JUNE 25-27, 1981: Annual Meeting of the Wisconsin Academy of Family Physicians, Hyatt Regency Hotel, Milwaukee. Info: Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122.

JUNE 27-JULY 11, 1981: *Scandinavian Holiday,* sponsored by the State Medical Society of Wisconsin. Cost: $1,998, round trip Milwaukee or Madison to New York to Copenhagen with return from Stockholm via Northwest Orient Airlines. Reserve space for $150 and final payment due on April 15, 1981. Info: Dittmann Tours, Inc, PO Box 199, Northfield, MN 55057, or contact Lee Johnson, SMS, toll-free 1-800-362-9080.

JULY 17-19, 1981: Clinical Management of Coronary Disease and Exercise Testing, Lake Geneva—The Abbey. Approved for Category 1 credit by AMA; prescribed credit by Wisconsin Academy of Family Physicians. Info: Director, CME, International Medical Education Corp, 64 Inverness Drive East, Englewood, Colo 80112 (ph 1-800-525-8646, ext 105).

5-6/81

State Laboratory of Hygiene

VIROLOGY FOR PHYSICIANS
Friday, July 10, 1981—Madison

at the State Laboratory of Hygiene, University of Wisconsin Center for Health Sciences, 465 Henry Mall, Madison, Wisconsin 53706

This one-day seminar on viral diseases will cover topics of current interest to practicing physicians. Presentations will include: respiratory viruses, viral myocarditis, arboviruses, hepatitis viruses and tests, slow virus infections of the brain, and herpesvirus infections. Seminar is designed to present current information on epidemiology and diagnosis of these important viral diseases.

FACULTY: Stanley L Inhorn MD, Donn D'Alessio MD, Gabriele ZuRhein MD, Elliot C Dick PhD, R Golubjatnikov PhD, Wayne Thompson DVM PhD, Todd McPherson MS, and Richard Circo MS.

Application forms may be obtained by contacting Gail Fadenrecht (608) 262-3911 or Margaret A Hutchinson (608) 262-1293. Registration fee: $10/person. Do not submit fee with application; it will be collected at time of registration. Registration: 8:00-8:30 AM, Lobby, State Laboratory of Hygiene.

Course meets criteria for 0.6 CME Units in Category 1 for PRA-AMA.

JULY 24-25, 1981: *Current Emergency Care Problems,* Wisconsin Center, Madison. Sponsors: University of Wisconsin Emergency Medical Services Program; US Dept of the Army, Office of the Surgeon General; and UW-Extension, Dept of Continuing Medical Education. Audience: All physicians, nurses, and allied health professionals who deal with emergency care. Credit: 11 hours AMA Category 1; Family Practice credit pending; American College of Emergency Physicians credit pending; AOA credit pending; 11 hours University of Wisconsin Continuing Education credit. Highlights: Program designed to allow rapid review of the subject with both structured plenary sessions and open discussion time with the faculty. Second day is devoted to hands-on workshops, insuring your practical involvement. Fee: $110 physicians; $85 nurses, residents, allied health professionals. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706 (ph 608/263-2856).

AUGUST 2-7, 1981: *Perspectives in Anesthesiology,* Tucson Hospital Education Program, The Abbey on Lake Geneva, Fontana.

AUGUST 7-8, 1981: *Common Management Decisions in Medicine,* University of Wisconsin Memorial Union, Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Medicine; and University of Wisconsin-Extension, Department of Continuing Medical Education. Approved credit Category 1 AMA, AAFP, and AOA. Info:

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
1992—Apr 23-25	

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

AUGUST 24-25, 1981: *Uses and Abuses of Antibiotics in Clinical Practice*, Heidel House Resort, Green Lake. Sponsored by Berlin Memorial Hospital. Info: Linda E Nevers, CME Coordinator, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, Wis 54923. Phone: 414/361-1313.

SEPTEMBER 11-12, 1981: *Seminars in Pediatrics*, University of Wisconsin Clinical Science Center, Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Pediatrics; and University of Wisconsin-Extension, Department of Continuing Medical Education. AMA credit Category I; AAFP pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

SEPTEMBER 17-19, 1981: *Infectious Diseases*, Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Medicine; and University of Wisconsin-Extension, Department of Continuing Medical Education. AMA Credit Category I; AAFP and AOA credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

"WATS" LINE FOR MEMBERS

As a new service for its members, the State Medical Society of Wisconsin has installed a toll-free WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8 00 am and 4 30 pm weekdays The number to dial is

1-800-362-9080

25th ANNUAL MEETING
American Association of Medical Assistants, Inc
SEPTEMBER 19-26, 1981
Hyatt Regency Hotel—Milwaukee
Host: Wisconsin Society-AAMAI
Theme: *Today's silver—tomorrow's gold*

Welcome party: Sunday evening, September 20, to share a bit of Wisconsin "gemutlichkeit" in a beer garden atmosphere

Official convention opening: Monday evening, September 21, with opening session of House of Delegates

Formal dinner: Wednesday evening, September 23, with awarding of certification pins and certificates to those who have successfully completed the national Certification Examination this past year.

Many interesting educational sessions and workshops throughout the week, along with organizational information and meetings

Between times there will be exhibits from many professional groups to visit, and the Arts and Crafts from many members to view

Inaugural banquet: Friday, September 25, when presidents of all the State Societies are introduced in the Parade of Presidents, highlighting the past 25 years, and new officers installed

General Chairman: Alice Budny
Vice Chairman: Carol Jean Beaver, RT

For registration blanks, write: American Association of Medical Assistants, Inc, One East Wacker Drive, Suite 2110, Chicago, Illinois 60601; or phone: (312) 944-2722

ANTIBIOTICS

Uses and Abuses in Clinical Practice

SUN & MON, AUGUST 24 & 25, 1981

Heidel House Resort and Conference Center

GREEN LAKE, WISCONSIN

Program includes sessions addressing use of antibiotics in:

- Surgical infections
- Surgical Gynecology
- Soft tissue infections
- Lower respiratory infections
- CNS infections
- Office Gynecology
- Pediatrics
- Upper respiratory infections
- Urinary tract infections

As well as:
- Pharmacology of antibiotic groups
- Laboratory methods in infectious diseases
- Prophylactic antibiotic use

SPEAKERS:

Michael W Rytel, MD—Prof of Med; Head, Div of Infectious Disease, Medical College of Wisconsin, Milwaukee

William A Craig, MD—Chief, Infectious Disease Section, Middleton Memorial Veterans Hospital, Madison

Richard J Boxer, MD—Clin Instr, University of Wisconsin, Div of Urology, Dept of Surg, Milwaukee

David W Lillich, MD—Asst Prof, Family Practice, St Mary's Program, Medical College of Wisconsin, Milwaukee

Richard E Condon, MD—Prof & Chrmn, Dept of Surgery, Medical College of Wisconsin, Milwaukee

Starkey D Davis, MD—Prof, Dept of Pediatrics & Microbiology, Medical College of Wisconsin, Milw Children's Hosp, Milwaukee

Dennis G Maki, MD—Head, Infectious Disease Section, University of Wisconsin Hospital & Clinics, Madsion

Michael Varnar, MD—Asst Prof, Dept of Obstetrics-Gynecology, University of Iowa Hospitals & Clinics, Iowa City, Iowa

CONFERENCE FEE: $85 (includes tuition, materials, coffee breaks, lunch and dinner)

CREDIT: This program has been accredited for 14 Category I credits

FOR MORE INFORMATION CONTACT:

Linda E Nevers, Berlin Memorial Hospital
225 Memorial Drive, Berlin, Wis 54923
(414) 361-1313, ext 254

SEPTEMBER 18-20, 1981: Fall Meeting, Wisconsin Society of Anesthesiologists, Lake Lawn Lodge, Delavan.

SEPTEMBER 23-26, 1981: *6th Annual Nuclear Cardiology Symposium,* Milwaukee. Sponsored by Mount Sinai Medical Center, Milwaukee; and University of Wisconsin-Extension, Department of Continuing Medical Education; University of Wisconsin School of Medicine, Milwaukee Clinical Campus, Cardiovascular Disease Program; American Heart Association; and Society of Nuclear Medicine. AMA Category I; UW Continuing Medical Education Units; VOICE. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

SEPTEMBER 25-26, 1981: *The High-Risk Patient with Dental Problems,* Madison. Sponsored by University of Wisconsin-Extension, Department of Continuing Medical Education; University of Wisconsin, School of Medicine; and Wisconsin Chapter, Academy of General Dentistry. Credit: University of Wisconsin Continuing Education Hours; Fellowship and Mastership credit, Academy of General Dentistry. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

OCTOBER 14-17, 1981: *Wellness and Cardiovascular Health Symposium,* in celebration of the 10th anniversary of the LaCrosse Exercise Program. Involving: Adult Fitness, Patient Education, School Fitness, Exercise Testing, Community Fitness, Cardiac Rehabilitation, Exercise Physiology, Industrial Fitness, Sports Medicine, and Wellness. Inquiries: LaCrosse Exercise Program-Workshop Unit, Mitchell Hall, UW-L, LaCrosse, Wis 54601 (ph 608/785-8686).

Ninth Annual Illinois Congress on Continuing Medical Education

September 11-12, 1981

Friday, Sept 11, 7:45 pm to Saturday, Sept 12, 5:00 pm

Oak Brook Hyatt Hotel, Spring & Harger Roads

Oak Brook, Illinois

How Physicians Learn: Effective Methods in CME

This year's Congress, sponsored by the Illinois Council on Continuing Medical Education is the second of a four-year program cycle presenting all the fundamentals of CME planning. The 1981 program focuses on effective learning methods as well as skill in selecting methods likely to achieve specific CME Program Goals and Learning Objectives.

Highlighting this year's program will be *Howard S Barrows, MD,* Associate Dean/Education Affairs, Southern Illinois University School of Medicine, known internationally for his work in *problem-solving* and *simulations* in medical education.

Most of the Congress consists of small-group workshops, such as: Matching Methods to Needs, Teaching with Technology, Self-Directed Learning Techniques, Do's and Don'ts of Didactics, Medical Audit as a Learning Method. There also will be a special workshop for non-physician CME Coordinators.

For additional information, write or call the **Illinois Council/CME, 55 E Monroe, Suite 3510, Chicago, Illinois 60603 (ph 312/236-6110).**

MIDWEST

JULY 18, 1981 (Illinois): AMA one-day intensive course on improving English pronunciation for foreign physicians. Formal credit in CME. Info: Henry Mason, Division of Professional Relations, AMA, 535 N Dearborn St, Chicago, IL 60610. Registration fees: $130 AMA members; $170 nonmembers; and $80 residents.

JULY 21-22, 1981 (Illinois): *Ninth Annual Breastfeeding Seminar for Physicians,* Conrad Hilton Hotel, Chicago. Approved 14 credit hours in Category I of AMA-PRA. Info: Carol Kolar, RN, Continuing Medical Education, La Leche League International, Inc, 9616 Minneapolis Ave, Franklin Park, Ill 60131, phone 312/455-7730. p5-6/81

AUGUST 20-23, 1981 (Illinois): Sixth annual convention, American College of International Physicians, Inc, Holiday Inn, Lake Shore Drive, Chicago.

AUGUST 29-SEPTEMBER 12, 1981 (Illinois): Illinois State medical Society announces new travel program, an *Alaskan Cruise,* aboard Sitmar Cruises' elegant TSS FAIRSEA, sailing from San Francisco. Arrangements made for a CME seminar. Flights from Madison and Milwaukee to San Francisco at cost of $175. Info: Illinois State Medical Society, 55 East Monroe St, Suite 3510, Chicago, Ill 60603 (ph 312/782-1654). g5-7/81

SEPTEMBER 25-27, 1981 (Indiana): *Second National Seminar on Community Cancer Care,* Hyatt Regency, Indianapolis. Sponsored by the Clinical Oncology Center and the Graduate Medical Center at the Methodist Hospital of Indiana, Inc. Info: Office of Continuing Medical Education, Methodist Hospital of Indiana, Inc, 1604 N Capitol Ave, Indianapolis, Ind 46204 (ph 317/924-8288). g5-8/81

OCTOBER 1-3, 1981 (Nebraska): Nebraska Medical Association Fall Session, Lincoln Hilton Hotel, Lincoln.

OCTOBER 2-4, 1981 (Ohio): *Midwest Forum on Allergy,* Stouffer's Inn, Cleveland, Ohio. Co-sponsored by the Cleveland Allergy Society and Ohio Allergy Society. Approved 14 credit hours Category I of AMA-PRA. Info: Joseph Kelley, MD, Cleveland Clinic, 9500 Euclid Ave, Cleveland, Ohio 44106 regarding scientific meeting and hotel reservations. 6/81

OTHERS

JULY 14-16, 1981 (Philippines): Medical Continuing Education on Internal Medicine and Cardiology, Manila Hotel, Manila, The Philippines. Info: Center for Continuing Education Programs (approved for Category I credit), c/o Hermosa Travel, Inc, 2526 N Lincoln Ave, Chicago, Ill 60614; tel 312/472-1280 (out-of-state call collect). (The same program will be presented again in Manila on Jan 2-4, 1982.)

JULY 29-AUG 8, 1981 (Caribbean): Ten-day cruise, departs Ft Lauderdale on July 29 and stops at St Maarten, Antigua,

SNOWMASS/VAIL "MEP" SKI SEMINAR

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Ski Snowmass, Colorado the week of December 19, 1981 or the week of March 20, 1982; or ski Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Seminars comply with IRS rules to make trip expenses deductible for doctor and spouse. For brochure and lodging information contact: MEP, An Education Corporation, 906 Cooper Ave, Glenwood Springs, Colorado 81601; or call 800/525-3402. 6-9/81

Barbados, Martinique, and St Thomas. Approved 23 credit hours of Category 1 of AMA-PRA. Info: International Conferences, Suite C, 189 Lodge Ave, Huntington Station, NY 11746. Phone: 516/549-0869.

AUGUST 10-11, 1981 (Washington, DC): *Antibiotic Review —1981,* Sheraton Washington Hotel, Washington, DC. Contact: Sandy McMillan, 67 Peachtree Park Dr, Suite 221-D, Atlanta, GA 30309. g6-7/81

AUG 22-SEPT 5, 1981 (Mediterranean): Fourteen-day cruise, departs Venice, Italy, and visiting Egypt, Israel, Turkey, and Yugoslavia. Approved 23 credit hours of Category 1 of AMA-PRA. Info: International Conferences, Suite C, 189 Lodge Ave, Huntington Station, NY 11746. Phone: 516/549-0869.

OCTOBER 17-21, 1981 (Louisiana): Annual Meeting, American Society of Anesthesiologists, New Orleans. Info: ASA, 515 Busse Highway, Park Ridge, Illinois 60068 (ph 312/825-5586).

OCTOBER 31-NOVEMBER 5, 1981 (New Orleans, La): American Academy of Pediatrics 1981 Annual Meeting, New Orleans, La. Info: American Academy of Pediatrics, PO Box 1034, 1801 Hinman Ave, Evanston, Ill 60204.

AMA

DECEMBER 6-9, 1981: Interim AMA House of Delegates, Las Vegas, Nev.

FEBRUARY 25-28, 1982: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill. ■

1981 AMA Seminar

Improving English Pronunciation for Foreign Medical Graduates

AMA Headquarters—535 N Dearborn St Chicago, Illinois (9:00 am-4:30 pm) Saturday, July 18, 1981

Course is designed to assist foreign physicians now in practice in the United States in improving spoken communications with their patients. Physicians attending will receive formal credits in continuing medical education.

Course will be taught by Mrs Elizabeth Lang, professor of English as a second language, Cuyahoga Community College, Cleveland, Ohio. Mrs Lang has developed a study manual and cassette tapes for home study.

There will be lectures and practice on producing the sounds of general American English, intensive oral drill and criticism of individual students, and practice in sustained discourse through reading and extemporaneous speaking.

Course is limited to 20 students. If it is oversubscribed by as many as 10, an additional course will be held on Sunday, July 19.

Registration fees: $130 for AMA members; $170 for nonmembers; and $80 for residents. (Includes nine practice tapes and 134-page manual.)

Further information on the course is available from Henry Mason, Division of Professional Relations, AMA, 535 N Dearborn St, Chicago, IL 60610. Course director is Mortimer Enright, head of the AMA's Speakers and Leadership Programs Section.

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Diet and Exercise:Synergism in Health Maintenance

NOVEMBER 3-4, 1981
Lake Buena Vista, Florida

(Walt Disney World Complex)

Symposium will focus on the role of nutrition *and* exercise in the promotion of health and the treatment of major health problems. Emphasis will be on the physiologic effects of moderate habitual activity coupled with sound nutrition practices; *ie,* the role of nutrition and exercise in health maintenance and in the treatment of some of our chronic degenerative disease states.

Sponsored by the Department of Foods and Nutrition, American Medical Association, in conjunction with the AMA's Council on Scientific Affairs and Council on Continuing Physician Education, and the Florida Medical Association.

For further information contact: Department of Foods and Nutrition, AMA, 535 N Dearborn St, Chicago, IL 60610.

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JULY 1981

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Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

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Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

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Valium® (IV)
diazepam/Roche

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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy
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1833 DOCUMENT ON DISPLAY AT MEDICAL MUSEUM

An original requisition for supplies at Fort Crawford was displayed for the first time at the Fort Crawford Medical Museum in Prairie du Chien during its Open House. The event, held the last weekend in June, attracted over 350 visitors.

The recently acquired document, dated June 23, 1833, is signed by Zachary Taylor who commanded the fort from 1829 to 1837 and later became a president of the United States. Sac Indian Chief Black Hawk was kept prisoner for a short time at Fort Crawford, after his surrender to Col Taylor in 1832. The Black Hawk Indian War made this fort a national concern which forced President Andrew Jackson to increase military troops in Prairie du Chien.

The fort was considered one of the best in the country. Work on the fort was under the immediate command of Lt Jefferson Davis, who married Taylor's daughter.

Today, the reconstructed fort military hospital is the site of the three-building medical museum complex owned and operated by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

The hospital building, a national historic landmark, houses displays of Indian medicine, homespun remedies, medical instruments and records of great moments of medical discovery. Exhibits trace 19th century medicine in Wisconsin, including a physician's office, dentist's office, and drug store.

The Hall of Fame in Stovall Hall features artifacts of Wisconsin physicians who have made outstanding contributions in the healthcare field. In another section of the building contemporary exhibits attempt to help visitors learn about the body and how to assume responsibility for its care. A highlight is the Dessloch Theater where visitors listen to the Transparent Twins explain organs of the body through light and sound.

The museum complex also has medical art on display.

The Fort Crawford Medical Museum is open daily through October 31, from 10 am to 5 pm.

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Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Too successful

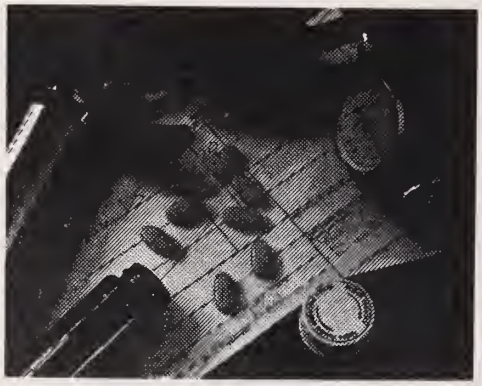
WHEN SOCIAL SECURITY began in 1935, life expectancy was only 61 years and the average person was not expected to live long enough to collect. Since that time life expectancy has climbed by 13 years to 74. More than one American in ten is now 65 or older and the elderly are becoming one of the fastest growing segments of the population. The median age of the US population is now 30, meaning that half of all Americans are 30 or older. Ten years ago the median age was 28.

American medicine can take some of the credit (or blame) for this phenomenon. The problems are that this results in a tremendous drain on the Social Security funds and also on the cost of medical care through such programs as Medicare and Medicaid. Surgical procedures are now being carried out that were not contemplated just a few years ago. Total joint replacements, new eye operations, cardiovascular procedures, and various protocols for malignancies have not only lengthened life but also made existence for the elderly more comfortable. In addition, many of the aged now rapidly recover from such previous disasters as pneumonia.

Nursing homes are filled with patients who may be in such facilities for many years. This too is very costly. Years ago it was customary for families to care for their own elderly relatives at home. What has happened now is that some of the parents have lived to such advanced ages that their own children are too old to care for them.

Russia apparently has found a solution of sorts to this problem. Death rates are soaring in the Soviet Union where men die at an average age of 63. Infant mortality now stands at 35 per 1000 births, a rate three times higher than in the United States. Soviet men are dying in droves in their 30s, 40s, and 50s. One reason that has been advanced for so many Russians dying young is that the Soviets operate a no-frills medical program. For example, their rigid rules demand that each five-inch long appendectomy incision be closed with only two stitches to economize on both time and string. This often leads to infection, hardly an efficient or economical situation. Another aspect of life in Russia is that of alcoholism. The average Soviet family now spends from a quarter to a half of his monthly food budget on alcohol. With the type of medical care available and with that amount of alcoholism, the lack of longevity is understandable. But perhaps a high blood vodka level makes it a little bit more bearable for the duration.—VSF ■

GOOD NEWS FOR DOCTORS



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Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug should be cautioned accordingly.

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Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

PRECAUTIONS:

Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down. Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

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Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Agent Orange help

TO THE EDITOR: I am very pleased that you printed Doctor Horvath's article on Agent Orange in the March issue of your publication. His article presented valuable information on a topic that may affect as many as 50,000 Vietnam veterans in Wisconsin.

Physicians should be aware that their veteran patients may present them with emotional as well as physical complaints which they associate with Agent Orange exposure. These symptoms may include nightmares or flashbacks to scenes in Vietnam, an emotional anesthesia in which the veteran is unable to get close to people, and/or fits of anger (see Diagnostic & Statistical Manual 309.81).

It is estimated that 40% to 60% of combat vets may be suffering from this delayed stress response.

A recent study by the Veterans Administration indicated that the most effective method of treatment is by peer counseling. A number of veterans groups in the state have started group sessions:

Vets House	Vet Center
134 E Johnson St	1610 N Water St
Madison, Wis 53703	Milwaukee, Wis 53202
(608) 255-8387	(414) 271-6557

Additionally the Disabled American Veterans Outreach Program has started several groups throughout the state. If you want to find out if there is a group in your area contact:

DAV Outreach
750 Lincoln Memorial Dr #303
Milwaukee, Wis 53202
(414) 278-0388.

Thank you very much.

Steve Meiers
Vets House staff person

Marijuana series

TO MR CLIFFORD C BEHNKE, City Editor, *Wisconsin State Journal:* On behalf of the 4800 physician members of the State Medical Society of Wisconsin, I applaud you and your newspaper for publishing the 10-part series on "Marijuana and Your Child" by Associated Press reporter John Barbour. The accompanying articles written by reporters of the *State Journal* discussing the marijuana problem locally are equally well-done.

The growing problem of marijuana use by the nation's youth has been a major concern of the physicians of the State Medical Society. While in recent years a substantial segment of the population has been under the mistaken impression that marijuana posed no real hazards to health, new research evidence appearing regularly points to the contrary. The Society has officially proclaimed marijuana to be a dangerous drug and for several years has been informing Wisconsin youth of the dangers of marijuana and other drugs through its annual Work Week of Health Program for senior high school students.

As a part of this commitment, the Society has just completed a brochure explaining what marijuana is, who uses it, and how it affects individuals. We plan on distributing the piece to Wisconsin junior and senior high school students, but the brochure is available to anyone on request. You and your staff may find the enclosed copy a source of additional information on the subject.

Again, I commend you on your newspaper's fine effort in bringing this problem to the attention of your readership.

Diane Upton
Communications Coordinator
State Medical Society of Wisconsin
Madison, Wisconsin

Sexual stereotyping

TO THE EDITOR: I heartily concur with Doctor McCormick's observations concerning the unfortunate programming of girls in school to pursue "womanly" careers of nursing, x-ray technology, etc while not also being offered the other options such as doctor, lawyer, banker, etc (Editorial: "Still a way to go—baby," *Wisconsin Medical Journal,* April 1981).

Certainly, all students should be encouraged to enter fields that utilize their potentials to the fullest and not be victimized by sexual stereotyping.

However, I find it more than a bit ironic while condemning sexual stereotyping in one paragraph, he commits it in the next. Specifically, he notes "Everyone remembers that the smartest students in the class were always girls." I, for one, do not remember any such thing. To assume that girls are smarter in school, or at least better students than boys, is just as much a sexual stereotype as the programming of girls to be nurses and boys to be

doctors. Fighting sexual prejudices in school is fine, but perhaps Doctor McCormick should start at home, first.

Robert L Scharz, MD
Menomonee Falls, Wisconsin

Society thanked

TO SOCIETY MEMBERS: Recently I participated in the Wisconsin Science Congress and was fortunate in being awarded first place. In addition to this honor, I received the Van Nostrands Scientific Encyclopedia which you donated. I am elated at having this wonderful reference book at my disposal.

My name may sound familiar to you—and, yes, I have a sister named Karen. Two years ago in this same competition she received a Van Nostrands. I enjoyed hers, but upon leaving for college there was a large space (literally!) left in the bookshelf. I am thankful for this award and hope you will continue to support this competition.

Don Middleton
6402 Landfall Drive
Madison, Wisconsin 53705 ■

1981-82 Legislative Directories—A handy reference now available

Copies of the new "1981-82 Legislative Directory" prepared by the Physicians Alliance Division of the State Medical Society are now available. The Directory provides the names, addresses and telephone numbers of the Wisconsin Congressional Delegation and State Assembly and Senate members for quick and easy access. Contact the SMS Physicians Alliance Office. ■

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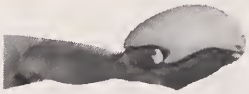

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Physicians in Wisconsin: Four dimensions of change . . .

Jane Maher, Madison, Wisconsin

SUMMARY. *The Wisconsin physician population is compared between 1978 and 1980. A net increase of 542 is shown to be the product of both gains and losses. Process in four areas: medical training, specialty, location, and age, is illustrated and discussed.*

IN 1980 THERE WERE 6965 physicians active in Wisconsin, a 30 percent increase since 1970. Recently the Bureau of Health Statistics estimated that by 1990 there will be 8889 physicians in the state, a 27 percent increase for the decade, 1980-1990.

Despite these increases, there has been serious concern over the adequacy of physician services in rural areas and in low income urban areas. At the same time the cost of training physicians and the costs borne by the public through Title XIX funding have raised questions about the ability of the state to support unlimited expansion of the physician supply.

The extent of these concerns has been reflected in the creation by the State of Wisconsin of several special bodies to consider the issues surrounding physician supply. These include the Primary Care Subcommittee of the Health Policy Council, the Special Study Committee on Medical School Class Size, and the Medical Education Review Committee. (This list dates only from 1975 and is by no means comprehensive.) Typically these various groups have struggled with the related issues of defining "primary care," the appropriate size of population which can be served by each practitioner or combination of practitioners, and the multiple effects of distance and other barriers upon utilization. More recently the structure of medical care, *ie,* the distribution of facilities, referral patterns, and practice organization, has been suggested as another determinant of the accessibility of health care.

Many efforts have been made to conceptualize the process by which medicine is changing, in order to direct public funds where they will be most effective.

Decisions in this area have been difficult because of uncertainty about when and why during their schooling physicians make the individual decisions which cumulatively determine the supply of services. In addition information has been lacking on out-migration and retirement, on the amount of services delivered by residents in training, and the effect on total supply of either increasing or decreasing the number of foreign medical graduates admitted to licensure.

By comparing the results of surveys conducted by the Bureau of Health Statistics it is possible to study over a two-year period some of the processes which affect the physician supply. The surveys are conducted in connection with the license renewal process of the Department of Regulation and Licensing. Every physician licensed to practice in the state is represented on the file. In addition, age, year and place of graduation from medical school, present location and specialty are available for virtually every licensee. Because license numbers are issued in sequence it is possible to identify new licensees and, by matching the files from consecutive surveys, to detect both returning physicians and out-migration. Thus it is possible to show not only the net increase but also how the distribution of physicians has changed by geographic location, specialty and age, and how the total supply is influenced by gains and losses of physicians trained at the two medical schools in the state compared to those trained elsewhere.

The loss to death and retirement of many small town solo practitioners was perhaps the most dramatic aspect of the shortages which became evident in the 1960s. Aging of the physician population has been an important dimension in planning for future supply. As efforts were made to replace the "horse and buggy" practitioners of the past, it also became evident that young physicians do not always remain in their first choice of practice location. The relative instability of the physician population in various 10-year age groups can be seen in Table 1. Between 1978 and 1980, 723 physicians migrated out of Wisconsin, retired, or died. Most of these (469) were under 40 years old. However, losses in these age groups were more than compensated by new physicians entering licensure. The two groups aged 40 to 59 years were stable, with just under 3.5 percent attrition. Loss to the age group over 60 years was 150, or 17.0 percent.

Ms Maher is from the Bureau of Health Statistics, Division of Health, Department of Health and Social Services, State of Wisconsin, Madison. Reprint requests to: Ms Jane Maher, Bureau of Health Statistics, Division of Health, DHSS, PO Box 309, Madison, Wis 53701. Copyright 1981 by the State Medical Society of Wisconsin.

Table 1—*Physician turnover in Wisconsin: 1978-1980 by age*

Age	1978*	Loss* 1978-80 No.	Loss* 1978-80 %	Gain** 1978-80	1980**	Net Gain 1978-80 No.	Net Gain 1978-80 %
Total	6423	-723	-11.3	1265	6965	542	8.4
<30	571	-208	-36.4	500	612	41	7.2
30-39	1953	-261	-13.4	625	2235	282	14.4
40-49	1683	-53	-3.1	73	1734	51	3.0
50-59	1333	-51	-3.8	44	1451	118	8.9
60+	883	-150	-17.0	23	933	50	5.7

*Shown by age in 1978
**Shown by age in 1980. Net gain 78-80 is the result of in-migration and aging.

NOTE: "Gain" includes 171 physicians licensed before February 1978, who returned to Wisconsin from out-of-state between 1978 and 1980, and 1094 physicians licensed after February 1978.

A total of 1265 physicians entered practice in Wisconsin between 1978 and 1980. Table 1 shows that this group was composed of a large number (500) who were less than 30 years old, and an even larger number (625) aged 30 to 39. There were an additional 140 physicians over age 40 who entered practice in the state in the two-year period. (The ages shown in the "gain" column are age in 1980.) The *net gain* to the age groups as they were constituted in 1980 is the result of physicians entering and leaving practice in the state and the aging of each cohort. The columns headed "net gain" in Table 1 summarize the effects of both migration and aging which result in the age composition of the physician population in 1980. The age group 30 to 39 has realized the largest gain, indicating that the "bulge" caused by the expansion, stimulated by federal funding, of medical school class size is affecting this age group. The age groups 40 to 59 (which are most stable so far as migration is concerned) have not yet been affected by the expansion of late 60s. It is not hard to predict, however, that larger relative increases in these age groups will be seen in the coming decade.

Table 2 displays in more detail the effect of the training process upon supply. Physicians graduated from medical school in Wisconsin are shown separately from all other graduates. In the two-year period Wisconsin lost a total of 195 physicians originally trained in the state while gaining 332. From out-of-state schools, the state lost 528 graduates, while in the same interval gaining 933. The rate of loss was higher for out-of-state graduates (13.5% compared to 7.4%). On the other hand, the number of out-of-state graduates entering practice in the state was nearly three times greater than the number of in-state graduates (933 compared to 332).

Comparison by year of graduation shows that the largest gains are for graduates of the years immediately preceding 1980. These, of course, are the current group in residency programs at the two state medical schools. Reading up the loss columns from 1977 to earlier years it can be seen that percentage losses are greatest in the years immediately following completion of residency, although they are consistently lower for Wisconsin graduates than for other graduates.

The gains include significant numbers of Wisconsin graduates returning following residency and/or practice elsewhere. Graduates from out-of-state were also attracted to practice in Wisconsin and in fact, at the end of the two-year period the overall proportion of physicians who were out-of-state graduates had increased from 61 percent to 62 percent, indicating that despite the apparent loss incurred by training physicians who leave the state upon completion of training, Wisconsin did, on balance realize a small advantage, relative to other states, from physician migration.

Another issue which has generated concern is the increasing specialization of physicians. While shortages of primary care physicians are being experienced in many areas, large increases have occurred in the non-primary care specialties. There has been growth in the array of specialties available in cities outside Madison and Milwaukee, but this has not alleviated all inequities in access to *entry* into the medical care system. Efforts to increase access to primary care have focused on encouraging the growth of family practice residency programs and retention of family practitioners in the state, as well as various types of satellite and physician extender programs. Tables 3 and 4 address changes in physician supply related to the factors of specialty and choice of practice location.

The specialties shown in Table 3 are from the list published by the Medical Examining Board. The losses and gains shown include changes in the specialty designation on record with the Board. Specialties are self-specified and do not necessarily indicate Board certification. The percentage lost in any given specialty, compared to the net gain,

Table 2—*Physician turnover in Wisconsin, 1978-1980: By year and place of graduation*

Year and Place of Graduation	1978	Loss 1978-80 No.	Loss 1978-80 %	Gain*** 1978-80	1980
WISCONSIN* GRADUATES					
Total	2525	-195	-7.7	332	2662
1970 and before	2077	-125	-6.0	34	1986
1971	61	-7	-11.5	13	67
1972	54	-3	-5.6	8	59
1973	64	-9	-14.1	14	69
1974	94	-17	-18.1	11	88
1975	85	-16	-18.8	17	86
1976	65	-15	-23.1	26	76
1977	25	-3	-12.0	100	122
1978-79**				109	109
OTHER GRADUATES					
Total	3898	-528	-13.5	933	4303
1970 and before	3126	-259	-8.3	241	3108
1971	126	-27	-21.4	62	161
1972	123	-36	-29.3	50	137
1973	120	-44	-36.7	64	140
1974	129	-43	-33.3	56	142
1975	125	-60	-48.0	88	153
1976	117	-44	-37.6	62	135
1977	32	-15	-46.9	151	168
1978-79**				159	159

*Received the MD degree from UW or MCW.
**There were two Wisconsin and one out-of-state 1979 graduates.
***See notes, Table 1.

Table 3—*Physician turnover in Wisconsin, 1978-80: By specialty*

Specialty	1978	Loss 1978-80 No.	Loss 1978-80 %	Gain** 1978-80	1980	% Net Gain 1978-80
State Total	6423	-723	-11.3	1265	6965	8.4
General/Family Practice*	1319	-186	-14.1	235	1368	3.7
General Surgery	522	-68	-13.0	71	525	0.6
Internal Medicine	870	-131	-15.1	218	957	10.0
Obstetrics-Gynecology	349	-21	-6.0	47	375	7.4
Pediatrics	395	-54	-13.7	99	440	11.4
Radiology*	319	-29	-9.1	54	344	7.8
Orthopedics*	237	-14	-5.9	51	274	15.6
Ophthalmology	222	-20	-9.0	41	243	9.5
Urology	124	-12	-9.7	17	129	4.0
Psychiatry*	370	-34	-9.2	82	418	13.0
Pathology*	246	-22	-8.9	33	257	4.5
Ear-Nose-Throat	118	-13	-11.0	22	127	7.6
Dermatology	93	-10	-10.8	10	93	
Anesthesiology	280	-24	-8.6	58	314	12.1
Emergency Medicine	90	-16	-17.8	26	100	11.1
Cardiology	114	-6	-5.3	21	129	13.2
Gastoenterology	62	-4	-6.5	7	65	4.8
Neurology*	141	-25	-17.7	32	148	5.0
Allergy	44	-6	-13.6	5	43	-2.3
Thoracic Surgery	51	-5	-9.8	5	51	
All Other/Unknown*	457	-23	-5.0	131	565	23.6

*The specialties shown in this table are from the list maintained by the Medical Examining Board. General and family practice have been combined, as have radiology and diagnostic radiology, orthopedics and orthopedic surgery, psychiatry and child psychiatry, pathology and clinical pathology, and neurology and neurological surgery. In addition 24 specialties are included in "all other." Of these, oncology, therapeutic radiology, immunology, physical rehabilitation, and alcoholism each had a growth rate over 24%. There were 82 unknowns in 1978, 98 in 1980.

**See notes, Table 1

Table 4—*Physician turnover in Wisconsin, 1978-1980: By health service area*

Health Service Area	1978	Loss 1978-80 No.	Loss 1978-80 %	Gain* 1978-80	1980	Net Gain 1978-80 No.	Net Gain 1978-80 %
State Total	6423	-723	-11.3	1265	6965	542	8.4
Southern (HSA 1)	1526	-269	-17.6	370	1627	101	6.6
Southeastern (HSA 2)	2845	-279	-9.8	568	3134	289	10.2
Lake Winnebago (HSA 3)	445	-24	-5.4	49	470	25	5.6
Northeastern (HSA 4)	456	-35	-7.7	57	478	22	4.8
Western (HSA 5)	606	-70	-11.6	116	652	46	7.6
North Central (HSA 6)	454	-26	-5.7	91	519	65	14.3
Northwestern (HSA 7)	91	-20	-22.0	14	85	-6	-6.6

*See notes, Table 1.

is an indication of how "volatile" the specialty is. (The numbers shown include physicians in residency programs.) Note that the largest numerical gains were in the primary care specialties (*eg,* 235 physicians gained in general and family practice) but that these are also the most "volatile" (*eg,* 15.1% loss in internal medicine) and that while the primary care specialties made numerical growth, their percentage growth was smaller than that of several non-primary care specialties (*eg,* psychiatry, cardiology). Thus to the degree that the physician shortage is attributed to specialty maldistribution, the situation did not improve in the two-year period, 1978-80.

Table 4 shows the change in the physician supply by Health Service Area. Areas are defined for planning purposes as mandated by federal statute (PL 93-641), each being served by a planning agency located in the area. The Southern and Southeastern areas are centered on Madison and Milwaukee, respectively. While these areas showed the largest numerical net gain, their percentage gains were not the highest in the state. The relatively rural North Central area made the largest percentage gain (14.3%). This area covers the center of the state from Juneau and Adams counties north to the Michigan border and includes several growing medical centers, including the Marshfield Clinic. The Northwestern area showed a net loss which may be due in part to migration of physicians from Superior across the state border to the neighboring city of Duluth, Minnesota.

The changes by Health Service Area suggest that for the most part the increase in physicians is being realized outside of as well as in urban areas. A comparison of gains and losses in primary care physicians by hospital service area showed that 33 of the 72 areas had shortages in 1978, as measured by a methodology developed by the Medical Education Review Committee. Between 1978 and 1980, 16 of these had had a net gain in the number of doctors, while 13 had had a net loss in doctors and four had shown no net change. Thus geographical maldistribution was only slightly alleviated by changes occurring in the two-year period and the *relative* imbalance in the numbers of physicians in shortage and non-shortage areas worsened. However, the numerical (542) and percentage (8.4) overall increase was large enough to suggest that the "trickle down" effect of an increasing number of doctors will alleviate most shortages in the foreseeable future. ■

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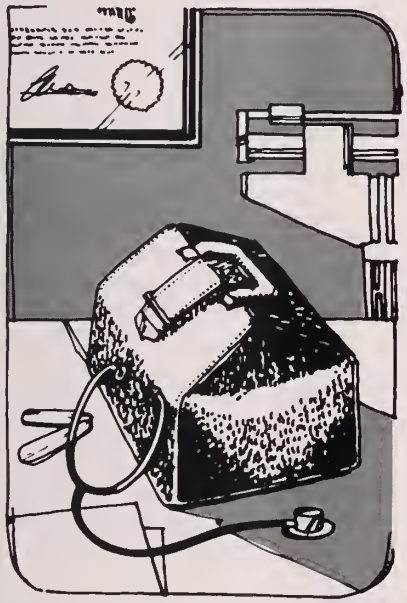

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Liver trauma: Community hospital experience: 1975-1980

Marvin E Sattler, MD, Milwaukee, Wisconsin

MORE THAN 300,000 people are injured in auto accidents each year. Abdominal injuries account for many of the more serious cases. One half of the abdominal injuries will have some type of liver trauma. In addition, high velocity gunshot wounds, shotguns, and stab wounds are responsible for an even greater number of liver injuries.

Before World War I the mortality rate for these injuries was 60%; during World War II, it dropped to 27%; and it dropped to 14% during the Korean War. At the present time the mortality rate is 9-10%. This improvement in survival has been achieved due to increased awareness of emergency room personnel, rapid transportation of victims, availability of blood, intensive care facilities, and new methods of hemorrhage control.

Approximately 85% of hepatic injuries are treated by simple suture, packing, or pressure. Only a small number requires hepatic resection, lobectomies, hepatic artery ligation, or vena caval cannulation. During the past 24 months, we were involved in the surgical care of three serious liver injuries. Because of these cases we became interested in the problem of injury to the liver and the various methods of hemorrhage control. We investigated how these were handled by three community hospitals in Milwaukee.

Liver injuries are best classified according to the method of Aldrete[1] of the University of Alabama.

Class I—Small lacerations including possible tear.

Class II—Moderate lacerations with significant bleeding.

Class III—Large intraparenchymal hematoma.

Class IV—Large lacerations with transection of identifiable branches of hepatic arteries, portal vein, hepatic vein, or bile ducts amenable to suture repair.

Class V—Large lacerations associated with retrohepatic veins and vena cava, resulting in massive hemorrhage.

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The signs and symptoms of hepatic injury are varied. Right upper quadrant abdominal pain and tenderness is the most common. Hypoactive bowel sounds, abdominal guarding, rigidity, and possible rebound tenderness also are seen. Shock may or may not be present at the initial examination. Other conditions such as fractures, head injury, alcoholism or drug intoxication can obscure abdominal findings. A careful history and physical examination and a high index of suspicion are important when treating a patient with trauma.

Diagnostic procedures include complete blood cell count, urinalysis, and complete x-ray films of the abdomen. Chest x-ray films are important if rib fractures are suspected. An abdominal tap with peritoneal lavage is an invaluable aid in making the diagnosis of hemoperitoneum. The peritoneal cavity is irrigated with 500-1000 ml of saline or distilled water and this fluid is then withdrawn. A laparotomy should be done if the red cell count is over 100,000 per cu cm; or the white cell count is over 500 per cu cm.

If the diagnosis of hepatic injury has been made, the patient should be transferred to the surgical suite as soon as blood is available. If hemorrhage is profuse, a laparotomy may be necessary to accompany rather than follow restoration of blood volume.

If time permits, other diagnostic methods are liver-spleen scan and angiography. Ultrasound, or computerized tomographic (CT) scan, has not proved too helpful. Central venous pressure lines, or Swan-Ganz catheters, are important in measuring fluid requirements and cardiac output.

Minor injuries and tears of the capsule or superficial lacerations of the liver can be controlled with packs, pressure, sutures, and topical agents such as micro-crystalline collagen (Avitene®) or polymerizing adhesive resins. Cautery, laser beams, and cryogenic surgery also have been used.

Moderate liver injuries involving deeper lacerations, tearing branches of the intrahepatic ducts or vessels can be treated by lobectomy or tractotomy with finger fracture of the deep laceration and suture or clipping of the ducts or vessels that are found.

Selective ligation of the hepatic arteries is another method of controlling hemorrhage. Mays[2] of the

University of Louisville reported successful control of bleeding in 59 of 60 cases. Historically, surgeons had been taught that ligation of any of the hepatic arteries will cause severe necrosis and sepsis. This myth was established by experiments of Graham and Cannell[3] in 1933. Dogs succumbed from severe sepsis following ligation of the hepatic artery. This was caused by Clostridium welchii; however, this bacterium is not normally present in the human liver. Arteriography has shown that hepatic arteries are not end arteries, and the translobular and subcapsular collaterals are capable of reconstructing blood flow in 24 hours. The extrahepatic collaterals, such as inferior phrenic and pancreatico-duodenal, also contribute to the blood supply of the liver.

Severe injuries of the liver with tearing of the retrohepatic and juxtahepatic veins require additional exposure best obtained by a sternal splitting incision. These injuries require control of the major veins by occlusion and insertion of a balloon catheter into the right atrium to shunt the flow of blood from the vena cava. Few of these injuries are salvaged even in major university centers. In 1908 Pringle[4] described a maneuver to control bleeding that is often helpful. The portal triad is compressed until bleeding is localized and controlled.

Postoperatively patients with severe liver injury often develop complications such as atelectasis, pneumonia, effusions, hemothorax, biliary fistulas, wound infection, and abdominal abscesses. Infection is a serious complication when intestinal injury is present, and prophylactic antibiotics and proper drainage are essential. Nasogastric decompression of the stomach is used to prevent ileus; and if any of the hepatic arteries have been ligated, it is necessary to keep the patient fasting for seven to ten days to maximum oxygenation of the portal vein blood. Blood glucose levels are maintained by using 10% glucose intravenously. Serum albumin should be given to aid in liver recovery or regeneration. Glucagon also has been used for its hemodynamic and glycogenolysis effects.

The most important principles of treatment are control of hemorrhage, debridement, and drainage.

As stated previously, 85% of liver injuries can be treated by simple methods. When associated with other organ injuries the mortality rate increases rapidly. Several authors feel that serious hepatic injuries are best managed by an organized and experienced trauma team with knowledge of sophisticated surgical techniques. Mays[2] has stated, "If patients with ruptured livers are allowed to bleed while being transported to a special trauma center, we can expect increased incidence of renal failure, pulmonary insufficiency, sepsis and death."

In a five-year period from 1975 to 1980, we found 34 cases of liver injury. Twenty-two were male and 12 were female. Ages ranged from 3 to 75 with an average age of 22.7 years. Injuries were due to stab wounds, gunshot wounds, industrial injuries, automobile and motorcycle accidents. Intoxication was a common problem in the vehicle injuries, making the diagnosis and history difficult to obtain. Multiple organ injuries were present in 29 of 34 cases. Six deaths were recorded. These deaths were all multiple organ injuries.

Medical care and observation were used in five cases with suspicion of liver injury and recovery. There is a recent development of selective management of abdominal injuries in the United States, with an increasing tendency not to operate on patients with minor liver injuries. The average length of stay for the 34 cases was 17.1 days. Simple packing of the wound was used in one case of liver injury and suture ligature was used in 19 cases. Two lobectomies and four tractotomies or partial lobectomies were done. There were two cases of hepatic artery ligation with cholecystectomy. Two separate right hepatic arteries were identified and ligated in one case, thus controlling the severe hemorrhage from the liver. This abnormal blood supply to the liver must be kept in mind and failure to control bleeding is often due to anatomical variations in arteries that were not controlled. Recurrent bleeding demands re-exploration as soon as possible. Cholecystectomy is done because of the common blood supply from the hepatic artery, and failure to remove it will result in necrosis and gangrene. Ligation of the most peripheral branch of the hepatic artery that controls bleeding is recommended to prevent liver damage.

One patient died within three hours of admission from profuse bleeding from retrohepatic veins that were not controlled. Splenectomy was done on three occasions, and colon injuries were repaired in three other patients with no infection or sepsis. Two of the case reviews revealed that incidental appendectomies were done without any complication; however, most authors feel this procedure should not be done as sepsis or infection is the most feared complication of liver trauma.

One accident victim with an injury to the right lobe of the liver was treated by suturing, packing, and common duct drainage. This procedure is not usually necessary unless hemobilia occurs. Lucas[6] reported that the problems related to decompression of the common duct were increase in intra-abdominal abscess, stress ulcers, hemorrhage, and ascending cholangitis.

Bleeding during and after surgery is a common problem due to excessive fibrinolysis, defective clotting factors, and disseminated intravascular coagulation after massive transfusions of stored blood. Therefore, all clotting factors should be measured preoperatively.

In summary, we have surveyed the liver trauma cases over a five-year period from 1975-1980 of three Milwaukee, Wisconsin community hospitals and have reviewed the surgical literature in respect to the

treatment of these injuries. Thirty-four cases were found and six deaths were recorded, for an overall mortality rate of 17.64%. These cases were operated on by many different surgeons, and review of the charts and the operative findings, made it difficult to classify the extent of the injury with the choice of the operative procedure.

It is important that the operating surgeon know the various methods of treatment available. Although the reports of Mays[2] are outstanding, only 3% to 4% of all serious liver injuries in the United States have been treated by some type of hepatic artery ligation in the past few years. This method may be too radical a procedure at this time and is not advocated by some authors. However, if the mortality rate of serious liver trauma is to be improved, we must investigate all methods of therapy; and hepatic artery ligation seems to have a place in the surgical treatment of this type of injury.

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Summary of consensus development conference on CEA

A NATIONAL INSTITUTES of Health Consensus Development Conference on CEA (carcinoembryonic antigen): its role as a Tumor Marker in the Management of Cancer, was held at the National Institutes of Health September 29-October 1, 1980. The conference was sponsored by the National Cancer Institute, assisted by the Office for Medical Applications of Research, Office of the Director, NIH.

At NIH, Consensus Development Conferences bring together biomedical investigators, practicing physicians, consumers, and others to provide a setting for the evaluation and review of the scientific soundness of a health or health-related technology, with an emphasis on safety and efficacy.

After two days of consideration of formal presentations by experts and comments by conference attendees, the Consensus Panel issued a statement reflecting its conclusions. This is a summary of that report.

Currently, measuring the levels of the tumor marker CEA in the blood of colorectal cancer patients is the best noninvasive technique for monitoring the disease after surgery. More studies are needed, however, before routine use of CEA can be advocated for monitoring patients with other types of cancer.

Many scientists have shown that CEA levels relate to the clinical stage of several types of cancer. CEA can help identify the disease stage and appropriate treatment, particularly in patients with colorectal or lung cancer. In addition, CEA is especially valuable in the continual monitoring of colorectal cancer patients.

CEA should be measured in colorectal cancer patients before surgery. About six weeks after surgery, another plasma CEA sample can provide a baseline for monitoring the disease course, treatment, and prognosis. Within six weeks after surgery, previously elevated CEA should return to normal levels. Failure to do so points strongly to the continuing presence of cancer.

Radioimmunoassay tests have shown that small amounts of CEA also are present in the circulation of a healthy person. Higher CEA levels are not only characteristic of cancer, however; CEA levels can rise from smoking, benign tumors, and inflammatory disorders. Moreover, about 15 to 20 percent of patients with proved cancers never have increased CEA levels. Therefore, CEA assays should not be used in cancer screening for persons with no symptoms, and assays should not be used independently to establish a diagnosis of cancer.

The usefulness of CEA in monitoring patients with other types of cancer is less convincing than it is for colorectal cancer. Future research should provide further insight into these questions.

It also would be beneficial to pursue research that might improve the assay's usefulness, such as studying CEA in combination with other markers, and establishment of a laboratory quality control system using a CEA standard preparation.

Copies of the complete Consensus Development Panel Statement on CEA are available from the Office for Medical Applciations of Research, National Institutes of Health, Building 1, Room 216, Bethesda, Maryland 20205. ■

Perinatology
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Perinatal challenge: Dealing with death

Natalie D Dahl, RN, MS, Madison, Wisconsin

EDITORIAL NOTE: *The care of the woman who has a perinatal loss is wrought with delicate problems. There is a lack of educational literature on the subject to guide the medical team in taking the right approach. The accompanying article should help perinatal care providers in dealing with the problem of perinatal death.*—LBC

IT IS OUT OF THE ordinary sequence of life events to die before, during, or shortly after birth. For most of us death "belongs" after childhood, school, work, parenting, and grandparenting. While death may seem uniquely out of place in the delivery room or in the nursery, it is certainly no stranger.

Speck & Kennell, in an article entitled "Management of Perinatal Death," indicate that in the United States stillbirths occur in one of every 80 deliveries and postnatal deaths as frequently as one in every 100 live deliveries.[1] Madison General Hospital, with a comparatively large "at risk" population, had one stillbirth in every 81.3 deliveries (12.3 per 1000) in 1980.

Physiologic and emotional changes during pregnancy help to prepare the mother to actively nurture her offspring. The infant's subsequent absence by death leaves her without a recipient for her emotional feelings or for her preparations for taking care of her baby. Without her baby to receive what she has prepared for, the new mother suffers a temporary loss of function.

Since the advent of perinatal intensive care, some 10 to 15 years ago, many health professionals have demonstrated growing interest in the impact of the high-risk pregnancy, the critically ill neonate, and even of the intensive care nursery itself on the family. More recently that interest has expanded to include the short- and long-term effects of fetal and neonatal death on the surviving family, especially the parents.

Perhaps there always has been some appreciation of the devastating loss suffered by parents on the death of an older child. At the same time there has been a curious lack of understanding of the impact on parents upon the death of the newly born infant. This is sometimes expressed by family, friends, and professionals in well-intentioned comments such as "It would have been worse if you had really gotten to know him," or "You're young. . .you can have other babies. . .the sooner the better." The approach to parents at the time surrounding death is changing; and, one would hope, their needs are beginning to be better understood and ***met.***

The mid-1970s' film entitled "Death of the Wished For Child" (OGR Service Corporation, Springfield, IL) traces the sequence of events as perceived by a young mother recalling the birth and death of her premature daughter. The mother shares the difficulties she faced in the weeks and months following the death and describes her attempts to understand the event, her responses to it, and her efforts to get her world and herself put back together again. The story, while interesting, is not unusual and variations of it can be found in articles in many popular magazines and in patient histories on many obstetrical units. The educational value of the film rests in the interpretations and teaching style of the narrator, Glen W Davidson, PhD. At the time the film was produced, Doctor Davidson was Professor and Chairman of the Department of Medical Humanities at Southern Illinois University, School of Medicine.

Doctor Davidson identifies "points of major vulnerability" that confront the newly grieving parent. The mother interviewed in the film is faced, upon awakening from an anesthetized delivery, with a situation that produces fear and disorientation instead of providing assistance. The mother's request to see her baby is denied on the basis that she (the mother) was physically unable. Since she was awake and wanted to see the baby, it is hard to imagine what the physical "inability" might have been. This decision made for the patient is, in Davidson's words, her "first point of major vulnerability." She makes attempts to try to learn about the baby, by first-hand confirmation. When this is denied the patient, the ground work may be laid for suspicions and fantasies about the baby she produced that are worse than reality. Family members and health professionals who want a parent not to see or have contact with their dying or dead baby will often explain they don't want to upset the mother even

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more. In the writer's experience and that of others who have worked with grieving parents, such well-intentioned protection often makes the long process of mourning more difficult.

In the film the second point of major vulnerability came for the mother when she reaches out to other people for support, understanding, and confirmation of what has happened. Being able to reach out to others in times of trouble is generally thought to be a strength. Friends, clergy, and nurses all tell her in various ways that her thoughts and questions are wrong. Rather than lending support to the grief-stricken mother when she turns to them, they increase her sense of being alone and disoriented. These reactions of others may come from their own anxiety and discomfort in the situation. It reinforces clearly how important it is for those who come in contact with parents whose baby has died how vulnerable and needful they are and to become familiar with the general progression of parental mourning.

The third point of major vulnerability occurs for this mother some months after her baby's death. When she is only really beginning to internalize the loss of her child, others around her assume the mourning is all over. It is a thing of the past. She begins to fear that she is becoming chronically disoriented and her self-confidence decreases. This particular patient has the strength and ability to seek professional help with her task of mourning. Many are unable to do this on their own, especially when support around them dwindles. This segment of the film is a powerful reminder of how long and individual grieving and mourning is and how quickly others return to "business as usual."

One might get the sense that the patient in the film simply had colossal bad luck in not getting positive help from all those to whom she turned. That may be true, but even in 1981 the sequence of events presented is not rare. The lesson to be learned is that the behavior of those around her, from delivery on, made her task of adapting to and recovering from the death of her wished for child more difficult. It behooves all of us to examine our own feelings and practices in this aspect of perinatal care.

REFERENCES

1. Speck WT, Kennell JH: Management of perinatal death. *Pediatr in Rev* 2:59-62 (Aug) 1980.
2. Film: *Death of the Wished for Child.* Colburn Film Laboratory, George W Colburn Laboratory, Inc, 164 N Wacker Dr, Chicago, IL 60606. ■

Abstracts

Computerized arteriography of the cerebrovascular system

WILLIAM D TURNIPSEED, MD; JOSEPH F SACKETT, MD; CHARLES M STROTHER, MD; ANDREW B CRUMMY, MD; CHARLES A MISTRETTA, PhD; and ROBERT A KRUGER, Depts of Surgery and Radiology, University of Wisconsin, Madison, Wis.: *Arch Surg* 116:470-473 (Apr) 1981

A unique method of computerized image enhancement makes it possible to visualize the arteriovascular system by intravenous (IV) injection of small doses of standard contrast agent. This technique has been used to study the intracranial and extracranial circulation of more than 100 patients. Occlusion, stenosis, aneurysmal change, plaquing, and ulceration can be identified by computerized IV arteriography. Failures (less than 10%) result from inadequate venous access, extravasation of dye, or patient motion. This technique avoids the need for arterial puncture, thereby significantly reducing the risks of arteriography. The major risk of IV arteriography is contrast medium reaction. There is a close correlation between IV and standard arteriographic images. Intravenous arteriography does not require hospitalization, is suited for repetitive testing, and has promise as a method of diagnostic screening for stroke prevention. ■

Adult hypertrophic pyloric stenosis managed by double pyloroplasty

Doctors George J Brahos and Eberhard Mack from the Department of Surgery, University of Wisconsin Clinical Sciences Center, described this condition in a paper published in the *Journal of American Medical Association,* May 16, 1980.

Hypertrophic pyloric stenosis is a relatively rare cause of gastric-outlet obstruction in adults. This is an entity that appears to be distinct and truly congenital in origin. It is characterized by thickening and hypertrophy of the pyloric muscle, but with the absence of fibrosis, which would imply inflammation.

They presented a case of a 76-year-old woman who was found to have a pylorus with a 3mm lumen. At surgery she was found to have notable thickening and hypertrophy of the pyloric muscle but no evidence of neoplasm, web, ulcer, or inflammation.

The obstruction was relieved with a double pyloroplasty technique, thus avoiding gastric resection. A wide pyloric channel was produced by transecting the circular muscle in two places, rather than one, and closure was completed without tension.

The authors conclude that this procedure seems ideally suited for adult hypertrophic pyloric stenosis and their case was the first to be managed by this technique.—VSF ■

Governmental Affairs takes up new legislation

The SMS Commission on Governmental Affairs took action on several legislative proposals at its June 10 meeting, including:

• **SB 381—Health Insurance Coverage Out-of-State** —Prohibits health insurance policies from excluding coverage of healthcare services provided outside Wisconsin, if the services are provided within 75 miles of the insured's residence. OPPOSED

• **SB 406—Athletic Trainer Licensure** — Provides for the licensure of athletic trainers by the Medical Examining Board. OPPOSED

• **AB 173—Premarital VD Testing** — A substitute amendment to this bill would repeal the law requiring premarital examinations for detection of venereal disease. SUPPORTED

• **AB 430—Worker's Compensation Access to Medical Records** — Amends the medical records law adopted last year to allow access to confidential medical records, without the informed consent of the patient, in cases where the records are needed for investigating, adjusting, or settling claims for benefits under Worker's Compensation. OPPOSED

• **AB 467 & SB 496—Choking Assistance Signs in Restaurants** — Requires the Dept of Health and Social Services to prepare and distribute signs to Wisconsin restaurants explaining how to assist choking victims. SUPPORTED

• **AB 489—Medicare Supplemental Policies** — Permits the State Commissioner of Insurance to establish, by rule, minimum standards for Medicare supplement insurance policies. SUPPORTED

• **LRB 2640/3—Public Health and Communicable Disease Law Revision** — Makes a series of changes to "update" the public health statutes. Areas of change include: 1) repeal or modification of outdated statutes; 2) modification of statutes to update terminology; and 3) major changes in communicable disease statutes and improve reporting and follow-up services. SUPPORTED

• **LRB 1953/4—Restructuring of the Dept of Regulation & Licensing** Transfers all examination, licensing, and administrative rule functions from the individual professional boards (including the Medical Examining Board) to the Dept of Regulation & Licensing. Discipline of licensees would remain a function of the individual boards. OPPOSED■

SMS-sponsored legislation introduced

The SMS Committee on Medical Liability was intimately involved in developing a piece of legislation that was introduced in the State Assembly in June. Assembly Bill 537, which is aimed at improving the Patient Compensation Panel system in Wisconsin, is the product of seven months of evaluation of the panel process by an ad hoc legislative committee.

SMS Medical Liability Committee members Russell Quirk, MD, Racine; Walter Moritz, MD, Fort Atkinson; and William Treacy, MD, Milwaukee, represented the State Medical Society on the ad hoc committee.

Among major provisions of this comprehensive legislation are:

. . .increasing the compensation paid to physician and attorney panel members from $75 to $150 per meeting;

. . .clarifying the term to be served by physician panel members so as not to overburden any physician with prolonged panel service;

. . .restricting the recovery available to claimants who initially request less than $25,000 and subsequent to a panel hearing file the case in court with a request for greater compensation; and

. . .specifying that any physician who, without good cause, refuses to serve on a panel is to be referred to the Medical Examining Board.

The bill has been referred to the Judiciary Committee and a hearing is anticipated after resolution of the budget bill.

The SMS Liability Committee is promoting the legislation on the grounds that it will assist in more timely and equitable resolution of medical liability disputes. ■

DHSS working to correct pediatric payments error

The SMS Physicians Alliance staff last month learned of significant errors in recent Medicaid payments to pediatricians. Earlier this year the Department of Health and Social Services (DHSS) directed EDS-Federal Corporation, the fiscal intermediary for the Wisconsin Medical Assistance Program, to implement 1980 profiles for physician payments under the program. At that time adjustments were made to the pediatric payment methodology which resulted in lower payments than prior to February 1, 1981. While the reduced payments to pediatricians occurred primarily in the southeastern part of the state, reductions may have occurred elsewhere. DHSS has recently informed the Society that adjustments are being made in the methodology used to pay pediatric claims. The Department is working with EDS-Federal to adjust the methodology to return it to the level in place prior to February 1, plus the adjustment in overall physician profiles that was implemented on that date. At this point it appears that physicians will have to resubmit affected claims. Physicians are urged to continue to submit claims in the usual fashion. A formal announcement from DHSS was expected in early July. ■

Workers Comp has "shopping list" of complaints

Mr John Byrnes, administrator of the Workers Compensation Division, appeared before the SMS Committee on Environmental and Occupational Health May 27 with a "shopping list" of complaints and problems his agency experiences in working with physicians on employee disability cases.

And at the top of that list was a proposed administrative rule change to set a maximum length of stay for independent medical examinations in Workers Compensation cases. Byrnes stated that his agency had just received its 500th complaint from an injured employee charging that the current four-day examination done by the Industrial Injury Clinic at Theda Clark Hospital in Neenah was an unreasonable demand. Byrnes is proposing an administrative rule change that would limit such an exam to a maximum of two days, one night.

"There is a disparity between what most physicians do (in regard to medical exams) and what they do at the Industrial Clinic in Neenah," Byrnes said.

Committee members wasted no time in expressing their disagreements with Byrnes' proposal and pointed out that cases referred to the Industrial Clinic were complex cases where, in most instances, the patient had been off of work for several months and no physical disability could be found.

"Psychological aspects enter into the vast majority of these cases," said Edward P Horvath, MD, Marshfield. "And if you can't find the cause of disability, a thorough examination must be performed."

A second problem area cited by Byrnes was finding physicians who would agree to offer tie-breaking opinions in Workers Compensation cases where the insurance company's physician and the employee's physician disagree on whether the healing process is completed. Medical staffs at both the Medical College of Wisconsin and the University of Wisconsin Center for Health Sciences have been asked to serve in this capacity and both have declined, Byrnes said.

"Physicians simply do not want to treat these patients because they don't want to become involved in the litigation process," he said.

Brynes said the Workers Compensation Division will be proposing legislation that will not allow a physician who is offering a tie-breaking medical opinion to be subpoenaed to testify.

Doctor Horvath said he too regretted that physicians don't take these cases on, but he cited reasons why this was occurring including: threats to MDs, their office staffs, and manipulation by attorneys for both sides.

Other common problems encountered by the Workers Compensation Division are: (1) physicians failing to show up at the hearing when they are subpoenaed; (2) physicians failing to fill out agency Workers Compensation Disability forms; and (3) health practitioners serving as "hired guns" for insurance companies and patients in Workers Compensation cases.

In this last instance Byrnes explained that he was referring to cases in which attorneys refer a client to a particular health practitioner because he already knows what that practitioner is going to say.

If physicians aren't willing to take on these cases, there are many other types of health practitioners who will, said Byrnes, citing chiropractors as an example.

"Chiropractors are jumping into these cases with both feet and have shown very little reluctance to make disability judgments on any kind of injury," he said.

Doctor Horvath summarized the problem as one of physician ignorance about the Workers Compensation law and said that the role of the Committee and SMS should be to educate physicians about the law. ■

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Interested in medical history?

The Aesculapian Society, a component of the CES Foundation, acts as the benefactor and operating unit for the Fort Crawford Medical Museum in Prairie du Chien, Wisconsin, and other medical history activities.

The Aesculapian Society is composed of member physicians and others who have a special interest in medical history. Persons with such an interest are encouraged to join The Aesculapian Society by becoming members in one of the several membership categories.

Individual or joint memberships are available to physicians and their families and to others who are accepted by the officers of The Aesculapian Society.

Regular members—annual membership contribution of $10. Such contributions are used for current operations.

Sustaining members—annual membership contribution of $25 or more.

Special members—widows or widowers of members of the State Medical Society receive the privilege of membership for three years without contribution.

Honorary members—contributions of $1000 or more.

Contributions of regular members are used for current operations of the Medical Museum and other medical history activities.

Contributions of sustaining and honorary members become part of a ***Museum Endowment Fund.*** Such gifts, bequests, or trusts are invested and only the income from this Endowment Fund is used to support the Museum's operations, maintenance, and development.

The Aesculapian Society seeks to develop and operate the Fort Crawford Medical Museum in Prairie du Chien, Wisconsin; collect and preserve artifacts and memorabilia related to the lives of Wisconsin physicians; cooperate with historical societies and other museums in support of medical history projects; and foster adequate financial support of the Medical Museum and other medical history programs by encouraging tangible and lasting gifts, bequests, and trusts to The Aesculapian Society by members of the medical profession, their families, and friends.

Gifts, bequests, or trusts may be made exclusively to The Aesculapian Society by earmarked designation via the CES Foundation.

Contributions for these purposes will be correctly designated if made out to the *CES Foundation-Aesculapian Society.* ■

AMA action on Wisconsin resolutions

Wisconsin's delegation to the AMA introduced four resolutions during the AMA's annual meeting in Chicago in June. The AMA House of Delegates:

- Passed a resolution requesting the AMA to evaluate US Senate Bill 8 which attempts to redefine independent contractors and take necessary action to assure protection of physician interests.
- Referred to the AMA Board of Trustees a resolution calling for the reversal of a Medicare regulation which prohibits traditional physician reimbursement based on reciprocal arrangements between attending and "covering" physicians.
- Adopted a resolution requesting the Board of Trustees to provide information on the costs related to each AMA council and committee as part of its routine annual financial reporting to the House of Delegates.
- Adopted a resolution encouraging the Board of Trustees to continue to review the structure, activities, functions and priorities of the AMA to aid the House of Delegates in determining the proper levels of resources necessary to carry out the AMA missions. (This resolution was passed in lieu of a similar one introduced by the Wisconsin delegation.)
- Wisconsin and Michigan delegations succeeded in joint efforts to reverse plans to terminate the Jail Health Care Program under AMA auspices at the end of 1981. It will be continued through 1982 if outside funding can be developed.

Further details on these and other actions of the AMA House of Delegates can be found in the June 19-26 issue of *American Medical News.* Highlights include:

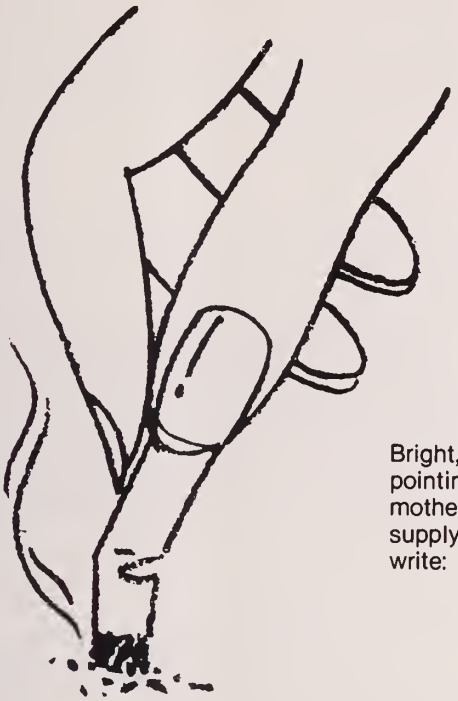
- Authorization of direct membership in AMA.
- Reorganization of AMA to emphasize its representation function.
- Discontinuation of direct programming in continuing education.
- Important reports on voluntary health planning, HMOs, and appropriateness review. ■

Nominations sought for Society offices

The SMS House of Delegates Nominating Committee will meet on Sunday, September 27, at 10:00 AM at SMS Madison offices to receive nominations for a slate of candidates to be presented at the 1982 House of Delegates Meeting, May 13-15.

Nominations are being sought for the following offices: President-elect for 1982-83; Treasurer for 1982-83; Vice Speaker of the House of Delegates for 1982-84; AMA Delegates and Alternate Delegates for calendar years 1983 and 1984.

Nominations, curriculum vitae, and a statement of willingness to serve if elected should be mailed to SMS offices prior to the September meeting date. ■



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CES FOUNDATION

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The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for April 1981.

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Membership Directory UPDATE

Prepared from the April 15, May 11, and June 5, 1981 Membership Reports and from member notifications to Wisconsin Medical Journal for updating the 1980-81 Membership Directory published in the January 1981 issue.

Physicians are reminded that the newly revised Constitution and Bylaws, as adopted by the 1981 House of Delegates and printed in the June 1981 *Blue Book* issue, state that "any member whose current year's dues have not been received by the secretary of this Society by May 15 shall be deemed in arrears and his name shall be removed from the membership rolls of his county society and this Society until such time as full dues for the current year have been received." Reelected members are those physicians who previously were members. Reinstated members are those physicians removed from membership who have been returned to the roster without a break in membership.

ASHLAND-BAYFIELD-IRON

Address changes

New	*Old*
AN	
Prentice, John W	
Route 1	1951 NE 39th St
Washburn WI 54891	Lighthouse Point, FL 33064

Removed from membership

Doty, John W

BARRON-WASHBURN-BURNETT

Address changes

New	*Old*
GS RET	
Matson, Kenneth L	
Route 1 Box 225	10738 Sante Fe Drive
Sarona WI 54870	Sun City AZ 85351

Removed from membership

Beehner, Michael L
Branham, Roger V
Fogarty, James P
Goellner, Paul G

BROWN

Address changes

New	*Old*
OBG	
Gallagher, Donald J	
120 Siegler St	1745 Dousman St
Green Bay WI 54303	

Removed from membership

Beno, Thomas J
Block, Robert T
Calaguan, Raymond R
Gallagher, Donald J
Guthrie, John M
Lacey, James V

CALUMET

Removed from membership

Pleviak, Denis J

CHIPPEWA

Address changes

New	*Old*
FP	
Rosenbrook, Gordon H	
1905 South Main St	1518 Main St
Bloomer WI 54724	
(715) 568-4650	
ORS	
Proett, A Frederick	
2501 County Trunk I	345 Prairie View Rd
Chippewa Falls WI 54729	

COLUMBIA-MARQUETTE-ADAMS

New members

FP
Christianson, Richard E
916 Silver Lake Dr
Portage WI 53901

Deceased members

Taylor, William A—Feb 8, 1981

CRAWFORD

New members

GP
Calkins, William N
Soldiers Grove WI 54655

DANE

New members

CD IM
Barrett, Kay M
1912 Atwood Ave
Madison WI 53704

GS
Binder, James P
6930 Pilgrim Rd
Madison WI 53711

AN
Boncyk, John C
5404 Mathews Rd #211
Middleton WI 53562

IM ON
Borden, Ernest C
K4/414 CSC
600 Highland Ave
Madison WI 53792

NS
Chanbusarakum, Krisada
20 S Park St #202
Madison WI 53715

P
Coleman, Frederick W
H6/160 CSC
600 Highland Ave
Madison WI 53792

U
Cummings, Kenneth B
G5/335 CSC
600 Highland Ave
Madison WI 53792

N OPH
Dreizen, Ivy J
20 S Park St
Madison WI 53715

N CHN
Edelman, Frederick S
20 S Park St
Madison WI 53715

PD
Ellis, Richard L
3206 Cedar Trail
Middleton WI 53562

OTO
Frank, Terrence W
7401 Century Pl, #8
Middleton WI 53562

IM
Gilbert, Robert D
1912 Atwood Ave
Madison WI 53704

DANE continued

New members

OBG
Haning Jr, Ray V
600 Highland Ave
Madison WI 53792

PD
Kellner, W Joseph
Dept of Pediatrics
600 Highland Ave
Madison WI 53792

PTH GS
Kurtycz, Daniel F I
2606 Westbrook Lane
Madison WI 53711

R
Liegel, Steven S
5326 Milward Dr
Madison WI 53711

IM PUD
Lingenfelter, Mark S
5808 Baskerville Walk
Middleton WI 53562

PS GS
Manning, Bradley L
1108 Nishishin Tr NE
Madison WI 53716

FP
Mullins, Maureen A
844 Prospect Pl
Madison WI 53703

R
Scheer-Williams, Mary
Dept of Radiology
600 Highland Ave
Madison WI 53792

N
Schutta, Henry S
Dept of Neurology
600 Highland Ave
Madison WI 53792

OBG END
Shapiro, Sander S
H4/630 CSC
600 Highland Ave
Madison WI 53792

OPH
Sondheimer, Stuart P
234 Randolph Dr, #210
Madison WI 53717

R
Stieghorst, Michael F
Dept of Radiology
600 Highland Ave
Madison WI 53792

R ON
Steeves, Richard A
Dept of Radiology
600 Highland Ave
Madison WI 53792

AN
Sykes, W Stuart
B6/387 CSC
600 Highland Ave
Madison WI 53792

PD
Yu, Kok-Peng
210 Green Lake Pass
Madison WI 53705

Address changes

New	*Old*
OPH **Anderson, Charles J** 314 Acadia Dr Madison WI 53717	622 Charles Lane
IM **Babcock, Alan W** 1846 Hoffman St, #101 Madison WI 53704	4604 E Washington Ave
PS **Bernsten, Stephen A** 7016 Applewood Dr Madison WI 53711	6410 Inner Drive
TS CDS **Chopra, Paramjeet S** H4/364 UW CSC 600 Highland Ave Madison WI 53792	H4/350 CSC
RET **Cooper, Garrett A** 1512 Sumac Dr Madison WI 53705	301 Circulo De La Paladin Green Valley AZ 85614
OTO HNS **Erbach, Thomas J** 218 Main St Wailuku Maui HI 96793	53 Merlham Dr Madison WI 53705
IM **Fisher-Beckfield, Paul W** 6681 Grandview Rd Verona WI 53593	4314 Tokay Blvd Madison WI 53711
AN **Hill, Nels A** 17105 Gulf Blvd N Redington Beach FL 33758	4502 N Federal Hwy Lighthouse Point FL 33064
P **Holt, Robert E** 8700 W Wis Ave, POB 175 Milwaukee WI 53226	9455 Watertown Plank Rd
US **Lacke, Clement L** 110 S Henry St, #1211 Madison WI 53703	4924 Whitcomb Dr Madison WI 53711
IM **Liebow, Mark F** 1000 North Oak Dr Marshfield WI 54449	1431 Morrison St Madison WI 53703
FP **Lloyd, Baldwin E** 524 West Verona Ave Verona WI 53593	505 Melody Lane
AN **McAleavy, John C** PO Box 207 Hendersonville TN 37075	20 S Park St Madison WI 53715
FP **Moore, James N** 149 Sugar Tree Lane Gallatin TN 37066	5714 Odana Rd Madison WI 53719
GP **Nelson, Eugene J** 216 West Main St Sun Prairie WI 53590	107 Church St
GS TS **Pellett, John R** G5/317 CSC 600 Highland Ave Madison WI 53792	253 South Point Rd Route 1 Verona WI 53593
PD **Tenney III, Horace K** 125 S Webster St, POB 7841 Madison WI 53707	126 Langdon St Madison WI 53702
GP U **Tormey Jr, Thomas W** 2453 Atwood Ave Madison WI 53704	16 N Carroll St Madison WI 53703
N IM **Zerofsky, Ronald A** 20 S Park St Madison WI 53715	7318 Harvest Hill Rd Madison WI 53717

County society transfers

Holt, Robert E to: Milwaukee

DANE continued

County society transfers

GP
Schutz, Weston J — from: Dodge
Rt 3 Foxmoor
Sun Prairie WI 53590

Reelected members

TS CDS
Bass Jr, James
2405 Northwestern Ave
Racine WI 53404

OBG
Luetke, William V
20 S Park St
Madison WI 53715

FP
Heggestad, Kay A
4221 Venetial Land
Madison WI 53704

PD
McCann, Michael L
6602 University Ave
Middleton WI 53562

Removed from membership

Batson, John F
Birnbaum, Marvin L
Brown, Michael W
Calvert Jr, James F
Chopra, Paramjeet S
Clinton, Gerald L
Connors, Dean M
Crennell, Ean H
Finlay, Jonathan L
Hendricks, Richard J
Jensen, Norman M
Juhl, John H
Kemp, Thomas S
Kwon, Tea Gil
Loevinger, Barbara
Mitchell, Torrey L
Moore, James N
Narsete, Thomas A
Oeth, Dennis A
Peden, John K
Reinholtz, Paul E
Sheldon Jr, Edwin O
Teetzen, Merle L
Vander Meer, James E
Washburn, Walter L

Deceased

Lappley, Walter F—Mar 20, 1981

DODGE

Removed from membership

Fary, Daniel R B

County society transfers

Schutz, Weston J — to: Dane

DOOR-KEWAUNEE

New members

FP
Timmermans, Peter W
720 Sunset Ave
Algoma WI 54201

Deceased members

Kerscher, Edward J—Mar 28, 1981

DOUGLAS

Removed from membership

Berry, Douglas G
Mann, Robert
Maryland, Daniel L

EAU CLAIRE-DUNN-PEPIN

Address changes

New	*Old*
GS	
Cameron, William G	
5575 North Shore Dr	250 Palmer Blvd
Eau Claire WI 54701	North Fort Meyers FL 33903
GP	
Hanley, Larry L	
1347 Prairie View Rd	2501 County Trunk I
Chippewa Falls WI 54729	
PD	
Hess III, Russell O	
2 Southwick Circle	733 W Clairemont Ave
Madison WI 53717	Eau Claire WI 54701
US	
Huston, Harold C	
624 East Tyler Ave	1603 Laurel Ave
Eau Claire WI 54701	
FP	
Kark, Richard A	
1021 Lexington Blvd E	5001 Monona Dr
Eau Claire WI 54701	Monona WI 53716

New members

AN
Gardner, Brett L
Rt 1 S Shore Drive
Altoona WI 54720

Removed from membership

Hanley, Larry L
Hess III, Russell O
Hill, Eldon F
Jones, Daniel L
Kimmel, Marco T
Leavitt, James R

FOND DU LAC

Removed from membership

Masunuru, Jagadeesware Rao
Peterson, Clifton R

GRANT

New members

PD
Heersma, James R
Rt 1 Box 13
Blue River WI 53518

Removed from membership

Lagman, Raul M

Deceased members

Randall, Murray W—Mar 25, 1981

GREEN

Address changes

New	*Old*
IM	
Witte, Keith B	
3556 Millikin Ave	2178 20th Ave
San Diego CA 92122	Monroe WI 53566

Removed from membership

Nemovitz, Paul M

GREEN LAKE-WAUSHARA

Address changes

New	*Old*
GS	
Tieman, Michael E	
Route 2	261 Memorial Dr
Berlin WI 54923	

IOWA

Address changes

New	*Old*
IM OBG	
Lindsey, Everett R	
112 High St	109 Fountain St
Mineral Point WI 53565	Dodgeville WI 53533

JEFFERSON

Address changes

New	*Old*
GP **Netzow, Earl J** Route 1 Box 51-F Cedar Grove WI 53015	Villas Seabrook Island John's Island SC 29455
FP **Tonn, Elizabeth C** 2713 Colfax Ave S Minneapolis MN 55408	1173 West Main St Whitewater WI 53190

Deceased members

Ambrose, Stephen H—Mar 21, 1981

KENOSHA

Address changes

New	*Old*
IM NEP **Ranieri, Rosanna M** 3734 Seventh Ave Kenosha WI 53140	3618 Eighth Ave
IM **Zelhen, Michael** 7108 First Ave Kenosha WI 53140	6310 Fifth Ave

New members

DR
Clark, Kenneth E
6530 Sheridan Rd
Kenosha WI 53140

Removed from membership

Zeihen, Michael

LA CROSSE

New members

GS
Anderson, Hans P
1836 South Ave
La Crosse WI 54601

FP
Bateman, William D
134 N Leonard St
West Salem WI 54669

CDS TS
Brenowitz, Jerold B
1836 South Ave
La Crosse WI 54601

FP
Carlson, Bruce A
524 North Elm St
La Crescent MN 55947

OPH
Kraft, Stephen E
212 South 11th St
La Crosse WI 54601

A IM
Kroger, George F
3370 East Ave South
La Crosse WI 54601

EM
Ledbetter, Emma K
1836 South Ave
La Crosse WI 54601

OTO
Overholt, Steven L
1836 South Ave
La Crosse WI 54601

P
Peterson, Lawrence P
1836 South Ave
La Crosse WI 54601

PD
Reimann, Leah A
1836 South Ave
La Crosse WI 54601

FP
Richardson, James D
434 North Star Dr
Holmen WI 54636

Address changes

New	*Old*
US **Anderson, N Philip** 1602 Mississippi St La Crosse WI 54601	2027 Cass St
FP **Engel, Charles H** 436 W Franklin St West Salem WI 54669	134 N Leonard St
IM GE **Oliai, Asghar** 3160 Elm Dr La Crosse WI 54601	2110 Wedgewood Dr
OPH **Skemp, Samuel J** 212 South 11th St La Crosse WI 54601	815 South 10th St

Removed from membership

Clemons, John E
Copps, Stephen G
Counihan, Colleen M
Ford Jr, Charles N
Goren, Carolyn C
Keimowitz, Rudolph M
Skemp, Samuel J

Reelected members

OBG
Beguin Jr, Everett A
1836 South Ave
La Crosse WI 54601

OM IM
Brailey Jr, Allen G
1836 South Ave
La Crosse WI 54601

OBG
Mader, Michael H
1836 South Ave
La Crosse WI 54601

OBG
Mahalras, Gregory H
1836 South Ave
La Crosse WI 54601

OBG
Peck, Theodore M
1836 South Ave
La Crosse WI 54601

OPH
Schmidt, Carl F
1836 South Ave
La Crosse WI 54601

LANGLADE

Address changes

New	*Old*
GS **Curran, William P** Route 2 Deerbrook WI 54424	2821 SW Fourth St Boyton Beach FL 33435
GP **Dailey, Dee William** Route 1 Box 156 Elcho WI 54428	16813 102nd Ave Sun City AZ 85351

Deceased

Dailey, Dee William—May 25, 1981

LINCOLN

New members

PD
Luthra, Madhu V
716 Second St
Merrill WI 54452

LINCOLN continued

Address changes

New	*Old*
FP **Carroll, James L** 318 N Seventh St PO Box 295 Tomahawk WI 54487	318 N Seventh St Tomahawk WI 54487

MANITOWOC

Address changes

New	*Old*
IM **De Bruyn, Donald J** PO Box 279 Manitowoc WI 54220	601 Reed Ave
P **Farkas, Mary E** 6235 Almond Ave Orangevale CA 95662	3545 Mather Field Rd Rancho Cordova CA 95670
IM **Gover, Mary A** PO Box 279 Manitowoc WI 54220	601 Reed Ave
OPH **Jiroch, John T** 2809A S Superior St Milwaukee WI 53207	2807 S Superior St
OPH **Radl, Cyril J** 1425 N 9th St, #4 Manitowoc WI 54220	7350 Via Paseo Del Sur, #1-108 Scottsdale AZ 85258

Removed from membership

Byun, Young S

MARATHON

Address changes

New	*Old*
OTO **Brodhead, Richard H** 2213 Ridge View Dr Wausau WI 54401	2727 Plaza Dr
AN **Koh, Tong B** 1250 Forest Hill Rd Wausau WI 54401	1230 Forest Hill Rd
AN **Low, Suzanne G H** 1250 Forest Hill Rd Wausau WI 54401	1230 Forest Hill Rd
FP **Nietert, William C** 2010 Little Rib Circle Wausau WI 54401	113 Ross Ave

Reelected members

TR R
Bourque, Adrian R
333 Pine Ridge Blvd
Wausau WI 54401

Removed from membership

Campbell, Daniel B
Osband, Gerald E

MARINETTE-FLORENCE

Removed from membership

Hofmann, Michael P
Hunold, Edward A

MILWAUKEE

New members

GS
Aquino, Manuel M
4893 N Green Bay Rd
Milwaukee WI 53209

PYA P
Black, David P
2600 Mayfair Rd
Milwaukee WI 53226

P PA
Blackwell, Barry
PO Box 342
Milwaukee WI 53201

R
Brutvan II, F Martin
729 Monroe Ave
South Milwaukee WI 53172

OBG
Di Ulio, Lynn K
2400 South 90th St, #210
West Allis WI 53227

IM
Drayna, Christopher J
324 E Wisconsin Ave
Milwaukee WI 53202

IM CD
Forward, Daniel J
7400 Harwood Ave
Wauwatosa WI 53213

PD
Foster, Beth L
3437 N 53rd St
Milwaukee WI 53216

GER END
Gambert, Steven R
5000 W National Ave
Wood WI 53193

IM
Hankwitz, Paul E
2015 E Newport Ave, #208
Milwaukee WI 53211

IM
Jewell, Kay E
2414 North 44th St
Milwaukee WI 53210

P CHP
Kalogjera, Ikar J
9501 Watertown Plank Rd
Milwaukee WI 53226

ORS
Langenkamp, James H
2040 W Wisconsin Ave
Milwaukee WI 53233

GS
Linn, Anthony J
2388 North Lake Dr
Milwaukee WI 53211

PTH
Madiedo, Gonzalo
8700 W Wisconsin Ave
Milwaukee WI 53226

OBG
Mahato, Prem P
2388 North Lake Dr
Milwaukee WI 53211

OPH
Olander, Kenneth W
7820 W Coventry Dr
Franklyn WI 53132

CLP
Olive, James A
8700 W Wisconsin Ave
Milwaukee WI 53226

IM GE
Regan, Patrick T
425 E Wisconsin Ave
Milwaukee WI 53202

OBG
Rogers, John C
3535 W Oklahoma Ave
Milwaukee WI 53215

IM
Welch, Cassandra P
2570 N Maryland Ave, #113
Milwaukee WI 53211

PM
Wertsch, Jacqueline J
12109 W Blue Mound Rd
Wauwatosa WI 53226

Address changes

New	*Old*
R **Abrams, Julian E** 5000 W National Ave Wood WI 53193	PO Box 1644 Milwaukee WI 53201
IM PUD **Banaszak, Edward F** 2315 N Lake Dr, #803 Milwaukee WI 53211	PO Box 15395 Milwaukee WI 53215

MILWAUKEE continued
Address changes

GP OM
Bernhart, Ervin L
3216 Menomonee River
Milwaukee WI 53222
2714 W Burleigh St

GPM
Biek, Richard W
3023 N Stowell Ave
Milwaukee WI 53211
841 North Broadway
Milwaukee WI 53202

PS GS
Bock, Harvey M
1218 W Kilbourn Ave, #517
Milwaukee WI 53233
606 W Wis Ave, #1706

U
Bourne, N Warren
2600 N Mayfair Rd, #545
Milwaukee WI 53226
700 North Water St
Milwaukee WI 53202

IM GE
Chua, David B
2040 W Wis Ave, Rm 505
Milwaukee WI 53233
1134 West North Ave

PM
Dagon, Eugene M
9191 Watertown Plank Rd
Milwaukee WI 53226
5851 North Shore Dr
Whitefish Bay WI 53217

U
Durkee, Charles T
2511 North 84th St
Wauwatosa WI 53226
3385 Cardinal Dr
Brookfield WI 53005

PTH
Falsetti, Frank P
1246 Gulf Dr, Apt B406
Sanibel FL 33957
6001 W Center St
thence to:
2525 South Shore Dr
Milwaukee WI 53207

IM CD
Gani, Mukhtar A
2315 North Lake Dr, #603
Milwaukee WI 53211
2266 N Prospect Ave
Milwaukee WI 53202

FP
Goldman, Stuart L
1834 W Wisconsin Ave
Milwaukee WI 53233
610 N 19th St
thence to:
2315 North Lake Dr
Milwaukee WI 53211

GS
Graber, John N
2956 N 70th St
Milwaukee WI 53210
Milwaukee WI 53226

OBG INF
Koh, Charles H
PO Box 503
Milwaukee WI 53201
2320 North Lake Dr

PH
Krumbiegel, Edward R
612 S Bayshore Dr
Elk Rapids MI 49629
3410 Gulf Shore Blvd N
Naples FL 33940

ORS
Laney, William H
2600 N Mayfair Rd
Milwaukee WI 53226
2500 N Mayfair Rd

ORS
McCabe, John O'D
2600 N Mayfair Rd
Milwaukee WI 53226
2500 N Mayfair Rd

FP
McDaniel, William P
3316 W Wisconsin Ave
Milwaukee WI 53208
13405 Burleigh Rd
Brookfield WI 53005

GPM OM
Meyer, Jules O
4822 Pine Ridge Rd
Grand Rapids MN 55744
1124 E Hermstage Rd
Milwaukee WI 53217

FP
Moede, James G
PO Box 502
Waupaca WI 54981
PO Box 41
King WI 54946

GP
O'Grady, Michael G
5701 S 124th St
Hales Corners WI 53130
2400 W Lincoln Ave
Milwaukee WI 53215

OPH
Owens, Andrew J
13335 Nicolet Ave
Elm Grove WI 53122
4441 W Fond du Lac Ave
Milwaukee WI 53216

D OS
Pittelkow, Robert B
324 E Wis Ave, Rm 325
Milwaukee WI 53202
161 W Wisconsin Ave

ORS OS
Waisman, Raymond C
10006 N Holmes Court
21W Mequon WI 53092
1707 N Prospect Ave
Milwaukee WI 53202

A
Weil, Harry R
3131 E Hampshire St
Milwaukee WI 53211
3301 Spanish Moss Terr
Lauderhill FL 33319

PS
Wynn, Sidney K
1218 W Kilbourn Ave, #517
Milwaukee WI 53233
606 W Wisconsin Ave

OTO
Yale, Russell S
10520 N Pt Washington
Mequon WI 53092
2015 E Newport Ave
Milwaukee WI 53211

Reelected members

IM OS
Filmanowicz, Edward V
3070 North 51st St
Milwaukee WI 53210

R IM
Kehoe, Michael E
1060 Hawthorne Ridge
Waukesha WI 53186

AN
Kevich, Nevenka T
1270 N Lake Shore Rd
Grafton WI 53024

P
Nock, Gilbert J
2350 North Lake Dr
Milwaukee WI 53211

DR
Shaffer, Katherine A H
8700 W Wisconsin Ave
Milwaukee WI 53226

Equagesic®℠

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

*INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information FDA has classified the indications as follows
"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache
Final classification of the less-than-effective indications requires further investigation
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin meprobamate, or ethoheptazine citrate
WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination
USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.
Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under
PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery
Suicidal attempts with meprobamate have resulted in coma shock vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants, e.g., caffeine Metrazol or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels
ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae ecchymoses, peripheral edema, and fever have also been reported
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported most of these returned to normal without discontinuation of the drug
Impairment of accommodation and visual acuity has been reported rarely
OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage specific parenteral electrolyte therapy for ketoacidosis and dehydration watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions
DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, PA 19101

for mild to moderate pain

Wygesic®IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g., driving a car or operating machinery. Patients should be cautioned accordingly.
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill, however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy have also been reported.
Ingestion of 10 grams or more of acetaminoophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I.V., simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g., caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977).
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Wyeth Laboratories
Philadelphia, PA 19101

MILWAUKEE continued

Reinstated members

IM CDS
Johnson, Gordon L
8700 W Wisconsin Ave
Milwaukee WI 53226

Removed from membership

Aprahamian, Charles
Bernhard, Victor M
Bodner, Aaron C
Bogost, Bruce R
Bonan, Joseph D
Bruns, W Theodore
Castillo, Marcelo G
Chambers, Charles H
Coffey, John M
Coron, Alfred J
Curtis, William C
Darin, Joseph C
D'Cunha, George F
Deshur, William
Devitt, Joseph S
Eichenberger, Charles R
Fehrer, Michael R
Field Jr, Brenton H
Finn, Charles J
Fricano, Salvatore
Gogan, Robert J
Good, Jeffrey M
Gross, Richard A
Guhl, James F
Gupta, Jagdish C
Hargarten, Stephen W
Heber, David L
Hodach, Richard J
Horwitz, S Fredric
Houghton Jr, William J
Huxley, Eliot J
Ivanovic, Zoran
Ivsin, Rostislav
Kah, William W
Kallas, Gerald J
Kim, Yong W
La Fond, David J
Larson, Craig
Lubsey, Vincent G
McLaughlin, Brian C
McLean, Zarah G H
Mellencamp, Frank J
Mendiola, Rolando M
Milbrath, John R
Mitcham, Leroy
Nair, B Ramachandran
Navarra, Miguel
Noonan, Patrick J
Nuyda, D'Jahlma A
O'Connor, Robert D
Ostrow, David E
Paz, Edward
Phillips, Wilson S
Polacek, Michael A
Puchner, Thomas C
Rao, Veluvolu K
Rhee, Yong H
Rodgers, Richard E
Sargent, James W
Scerpella, Jaime R
Schmidt, James R
Skibba, Joseph L
Slutzky, Nathan
Spiro, Herzl R
Stolp, Sherwood B
Smullen, William A
Thompson, Lee H
Travers, Howard D
Vasudevan, Sridhar V
Wiesen, Richard L
Yatso, Michael G

Deceased members

Charles, John D—Dec 5, 1980
Costello, Addis C—Apr 1, 1981
Goldberg, Syrene C B—Feb 23, 1981
Harrington, Earl T—Mar 23, 1981
Lubitz, Joseph M—May 15, 1981
Northey, Thornton M—Apr 16, 1981
Slotnik, Irvin L—Mar 25, 1981
Walton, William B—Apr 1, 1981

County society transfers

P
Holt, Robert E from: Dane
8700 W Wisconsin Ave
PO Box 175
Milwaukee WI 53226

MONROE

New members

FP P
Wade, Reynolds W
VA Medical Center
Bldg 18, Apt 3
Tomah WI 54660

Removed from membership

Gasem, Khaled Ali

Address changes

New	*Old*
FP	
Ahn, Helen H	
105 W Milwaukee St	325 Butts Ave
Tomah WI 54660	

OCONTO

Address changes

New	*Old*
GP	
Chung, Kim Y	
PO Box 258	1113 North Main St
Oconto WI 54153	
FP	
Heinzl, Glen J	
PO Box 229	1007 Pecor St
Oconto WI 54153	
GP	
Honish, John S	
PO Box 260	1113 North Main St
Oconto WI 54153	

ONEIDA-VILAS

New Members

IM
Swank, Lee A
203 Schiek Plaza Dr
Rhinelander WI 54501

Deceased members

Rosemeyer, Otto G—Apr 22, 1981

Removed from membership

Liebl, R Scott
Melcher, Peter J
Raduege, William E
Resan, Thomas K
Schell, Charles A
Schwartz, Henry J

Address changes

New	*Old*
PTH	
Hertel, Bruce F	
7306 Glencoe Dr	PO Box 567
Lake Tomahawk WI 54539	

OUTAGAMIE

Removed from membership

Bonner, Joseph N
Mielke, John E
O'Boyle, Robert F
Peterson, Lowell F
Stewardson, Richard H
Syverud, James C

OZAUKEE

Removed from membership

Corcoran Jr, William A
McManus, Douglas B
Perez, Celestino M
Pfeffer, Robert A

PIERCE-ST CROIX

New members

FP
Anderson, Michael D
990 Curtis St
Baldwin WI 54002

POLK

New members

FP
Kelsey, David P
Rt 3, Box 53A
Frederic WI 54837

PORTAGE

Removed from membership

Bergin, Steven C
Gauder, John P
Jones, Lawrence D
Katz, P Gary
Tomczak, Mark L

Reelected members

EM
Rifleman, Robert H
900 Illinois Ave
Stevens Point WI 54481

PRICE-TAYLOR

Address changes

New	*Old*
FP	
Lofland, Leo J	
Box 107A	Rt 2, Box 257
Ogema WI 54459	Stetsonville WI 54480
GP	
Murphy, James L	
PO Box 190	500 Birch St
Park Falls WI 54552	

Reinstated members

FP
Lalich, Roger A (DO)
101 N Gibson St
Medford WI 54451

Removed from membership

Frederick, T Bayard
Murphy, James L
Sargeant, James G

RACINE

New members

PD NPM
Glaspey, John C
5625 Washington Ave
Racine WI 53406

CD IM
Tierney, James F
1333 College Ave
Racine WI 53403

Address changes

New	*Old*
U	
Change, Hark C	
3803 Spring St, #203	312 Seventh St
Racine WI 53405	Racine WI 53403
PD ID	
Crast, Frank W	
6880 E McDowell Rd	5625 Washington Ave
Scottsdale AZ 85257	Racine WI 53406
PD	
Foreman, John W	
2405 Northwestern Ave	4701 Park Ridge Dr
Racine WI 53404	
PD	
Gardetto, Peter A	
2405 Northwestern Ave	475 Wind Ridge Dr
Racine WI 53404	
OBG	
Gass, Howard I	
2405 Northwestern Ave	3607 South Lane
Racine WI 53404	Franksville WI 53126
NS	
Kanshepolsky, Jose	
822 Wisconsin Ave	524 Main St
Racine WI 53403	
TS GS	
Miller, V Michael	
1505 Valley View Dr	3701 Durand Ave
Racine WI 53405	

Removed from membership

Bein, Robert
Bliwas, Arnold
Crast, Frank W
Irani, Sohrab R
McNeel, Laird
Miller, V Michael
Shack, James B
Wetzler, Robert J

ROCK

New members

CRS GS
Behrens, Susan F
1905 Huebbe Parkway
Beloit WI 53511

Removed from membership

Lee, Peter U
Manning, Timothy A
Miller, James R
Papadakes, Nicholas G
Pili Jr, Dionisio B
Schwaegler, Robert R

Address changes

New	*Old*
GP IM	
Farnsworth, Richard W	
1324 E Racine St	301 N Ocean Blvd
Janesville WI 53545	Pompano Beach FL 33062
D	
Levin, Harlan M	
94 South Harmony Dr	236 South Harbor Dr
Janesville WI 53545	Venice FL 33595
ORS	
Papadakes, Nicholas G	
9034 Westheimer Rd, #108	510 N Terrace St
Houston TX 77063	Janesville WI 53545

SAUK

Removed from membership

Bishop, Paul R

Deceased members

Henry, Richard A—May 17, 1981
Rouse, John L—Mar 21, 1981

SAWYER

Address changes

New	*Old*
GP IM	
Callaghan, Desmond H	
Route 8 Box 67	203 Parliament Dr
Hayward WI 54843	Horseshoe Bend AR 72512

SHAWANO

Removed from membership

Craft, George A

SHEBOYGAN

New members

FP
Pawlak, James R
904 N 9th St
Sheboygan, WI 53081

Removed from membership

Jackson, Thomas V
Twohig, George J

TREMPEALEAU-JACKSON-BUFFALO

Removed from membership

Schneider, O Mark

WALWORTH

Address changes

New	*Old*
IM	
Werbel, Harold J	
569 Laurel Heights	5084 Lakeridge Terr
Delavan WI 53115	Reno NV 89509

Removed from membership

Beattie, James W
Tavera Jr, Menandro V

WASHINGTON

Removed from membership

Bush, Frederick I

WAUKESHA

New members

OBG
Burch, Kim R
WI80 N7950 Town Hall
Menomonee Falls WI 53051

FP
White, Herbert C (DO)
W312 S4272 Highway 83
Genesee Depot WI 53127

GS
Keane, Patrick K
N84 W16889 Menomonee
Menomonee Falls WI 53051

Address changes

New	*Old*
OBG	
Chumbley II, Clyde M	
W180 N7950 Townhall Rd	PO Box 427
Menomonee Falls WI 53051	Menomonee Falls WI 53051
	thence to:
	11623 West Mequon Rd
	112N Mequon WI 53092
	thence to:
	9516 Fallson Court
	Cincinnati OH 45242

Reelected members

AN
Bellehumeur, Gerald C
6300 N Port Washington
Milwaukee WI 53217

TR ON
King, Douglas
5000 W Chambers St
Milwaukee WI 53210

D
Mielke, Donald J
1111 Delafield St
Waukesha WI 53186

Removed from membership

Clothier Jr, W J Kilburn
Helz, Timothy J
Herrmann, Richard A
Neumann, Jane L
Stroup, Daniel F
Thomas, Elaine M
Zarbock, Floyd M

WINNEBAGO

New members

PD
Gehringer, Robert E
411 Lincoln St
Neenah WI 54956

OBG
Holly, Robert J
712 Doctors Court
Oshkosh WI 54901

AN
Wex, Timothy G
PO Box 2512
Oshkosh WI 54903

Address changes

New	*Old*
GS	
Barton, Michael	
1546 Kehl Center	PO Box 3063
Dubuque IA 52001	Oshkosh WI 54903

Removed from membership

Bartizal Jr, Frederick J
Rao, Muralidhara S

WOOD

Address changes

New	*Old*
Stueland, Dean T	
1000 North Oak Ave	7623 McLean Dr
Marshfield WI 54449	Hewitt WI 54441

Removed from membership

Bowers, Timothy L
Malik, Saleem A
Tarabishi, Farida N

Deceased members

Doege, Paul F—Mar 26, 1981 ■

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North Carolina 27709

Obituaries

✓County, State, and AMA members

✓**Earl T Harrington, MD,** 81, Milwaukee, died Mar 23, 1981 in Milwaukee. Born June 9, 1899 in Antigo, Doctor Harrington graduated from Marquette University School of Medicine in 1926 and served his internship and residency at Milwaukee County General Hospital and Johnson Emergency Hospital in Milwaukee. He had practiced medicine in Milwaukee until his retirement in 1974. Doctor Harrington was a member of the "50 Year Club" of the State Medical Society of Wisconsin. Surviving are three sons; Thomas, Santa Barbara, Calif; Timothy, Wauwatosa; Michael, Milwaukee; and three daughters, Mary Resch, Milwaukee; Sister Ann Harrington, Chicago, Ill, and Kathleen Harrington of Milwaukee.

✓**Murray W Randall, MD,** 91, Boscobel, died Mar 25, 1981 in Divide, Colo. Born Oct 22, 1889 in Richland County, Doctor Randall graduated from Marquette University School of Medicine in 1914 and served his internship at Mt Sinai Hospital, Milwaukee. Doctor Randall practiced in Blue River from 1915-1950 and at Brookside Clinic and Hospital, Boscobel, from 1951-1958. Surviving are his widow, Ilah; a daughter, Mrs Fremont (Anamalia) Piercefield, Rockford, Ill; a son, Dr E M Randall, Boscobel; and a step-son, William Tweedy.

✓**Irvin L Slotnik, MD,** 61, Milwaukee, died Mar 25, 1981 in Milwaukee. Born Jan 20, 1920 in Buenos Aires, Argentina, Doctor Slotnik graduated from the University of Wisconsin Medical School, Madison, and served his internship at Mt Sinai Hospital, Chicago, Ill. His residency in internal medicine was completed at the Veterans Administration Hospital, Wood, and his residency in psychiatry was completed at the Medical College of Wisconsin. He served on the medical staffs of Deaconess, Lutheran, Milwaukee Psychiatric, Mt Sinai, and St Michael's hospitals in Milwaukee. Doctor Slotnik served on the Medical Examining Board of Wisconsin for two terms and also served as secretary of the Board in 1966. He was a member of the Wisconsin Psychiatric Association. Surviving are his widow, Mary; and two daughters, Deborah, Milwaukee, and Mrs. Jacqueline Goldner of New York.

✓**Paul F Doege, MD,** 83, former Marshfield surgeon and son of Marshfield Clinic co-founder, Karl W Doege, MD, died Mar 26, 1981 in Tucson, Ariz. Born Mar 18, 1898 in Marshfield, Doctor Doege graduated from Harvard Medical School in 1926 and served an internship in pathology at Peter Bent Brigham Hospital, Boston. From 1928-1930, he was house surgeon on the Fifth Surgical Service of Boston City Hospital. He returned to Marshfield in 1930 to practice surgery and was instrumental in establishing the laboratory for pathology study at St Joseph's Hospital where he also served as chief-of-staff. He left Marshfield Clinic in 1954 to establish the Paul F Doege Medical Center. He retired in 1966 and moved to Tucson in 1968.

Doctor Doege was editor of the *Wisconsin Medical Journal* from 1938-1939 and in 1949 he became regent in Wisconsin for the International College of Surgeons. He was a founder member of the Wisconsin Surgical Society. He also was a member of the American College of Surgeons and a member of the International College of Surgeons and the American Association of Railway Surgeons. Surviving are his widow, Erville; one daughter, Karlene Trott of Bermuda; and two sons, F Brooks, Houston, and Richard of Minneapolis.

✓**Edward Joseph Kerscher, MD,** 96, Casco physician since 1914, died Mar 28, 1981 in Algoma. Born Feb 19, 1885 in Kewaunee County, Doctor Kerscher graduated from Marquette University School of Medicine, and was still seeing patients at the age of 94. Surviving are a daughter, Mrs Harold (Helen) LeFevre, Green Bay, and a son, Edward of Milwaukee.

✓**Addis C Costello, MD,** 58, Milwaukee, died Apr 1, 1981 in Milwaukee. Born Dec 9, 1922 in Fond du Lac, Doctor Costello graduated from Marquette University School of Medicine and served his internship at St Joseph's Hospital in Milwaukee. His residency was completed at the Mayo Clinic, Rochester, Minn. Doctor Costello had been chairman of the Physicians Alliance Committee, a member of the Legislative Policy Committee and a delegate to the State Medical Society of Wisconsin from the Medical Society of Milwaukee County. He was the first president and chairman of the board of the Foundation for Medical Care Evaluation of Southeastern Wisconsin. He also served on the Commission on Peer Review of the State Medical Society of Wisconsin. He served as president of the Wisconsin Society of Internal Medicine from 1970-1971 and in 1978, the American Society of Internal Medicine presented him with a special award for his work in the area of peer review and upgrading the continuing education of specialists in internal medicine.

He was administrative chairman of St Joseph's Hospital Department of Medicine and also was a member of the Education Committee and the Executive Committee of the medical staff. He was a member of the Milwaukee Academy of Medicine, Milwaukee Internists Club and the Wisconsin Diabetes Association.

Surviving are his widow, Mary Lou; and five children, Beth, Minneapolis, Maureen, Kevin, Daniel, and Brian at home.

✓**William B Walton, MD,** 80, Milwaukee, died April 1, 1981 in Milwaukee. Born July 14, 1900 in Crawford County, Doctor Walton graduated from Marquette University School of Medicine and served his internship at Milwaukee Lutheran Hospital. He served for 38 years as a member of the medical staff of St Joseph's Hospital

in Milwaukee. Doctor Walton was a member of the "50 Year Club" of the State Medical Society of Wisconsin. Surviving are his widow, Mabel; one son, John, and a daughter, Ruth.

Thornton M Northey, MD, 78, former Milwaukee physician, died Apr 16, 1981 in Key Biscayne, Fla. Born Mar 27, 1903 in Hibbing, Minn, Doctor Northey graduated from the University of Minnesota School of Medicine and served his internship at Northwestern Hospital in Minneapolis, Minn. He was a member of the "50 Year Club" of the State Medical Society of Wisconsin. Surviving are three stepchildren.

Walter A. Brussock, MD, 81, formerly of Wauwatosa, died Apr 22, 1981 in Philadelphia. Born in Milwaukee, Doctor Brussock graduated from Marquette University School of Medicine. He served his internship at St Mary's Hospital, Oshkosh, and his residency at Philadelphia General Hospital. Doctor Brussock practiced medicine in Milwaukee until his retirement in 1973 when he moved to Narberth, Pa. He served on the faculty of Marquette School of Medicine and was a medical staff member of Lutheran, Milwaukee Children's, and Milwaukee County hospitals. Surviving is a daughter, Mrs Stanley Barrell of Narberth, Pa.

Otto Rosemeyer, MD, 65, Rhinelander, died Apr 22, 1981 in Rhinelander. Born Aug 1, 1915 in Loeningen, Germany, Doctor Rosemeyer graduated from Friedrich Wilhelm University, Berlin, Germany, and served his residency in Berlin hospitals. While in Berlin he studied under the world reknown Professor Sauerbruch and achieved high honors under him. Prior to his immigration to the New World, he studied at the Sorbourne University in Paris under Professor Obry in the then new field of plastic surgery. In addition he went to Switzerland for a month to work and observe Professor Niehaus who developed, in the early 50s, the fresh cell therapy. Among Professor Niehaus' prominent patients was Pope Pius XII. Doctor Rosemeyer practiced in Winnipeg, Canada, for two years before entering medical practice in Spring Green. In 1959 he became associated with the Northwoods Medical Associates (formerly Schiek Clinic). Surviving are his widow, Brigette; three children, Audrey and Otto Mark, students at the University of Wisconsin, Madison; and Ingrid of Rhinelander.

George H Brannon, MD, 71, Granville, Ill, died Apr 29, 1981 in Rochester, Minn. Born Mar 4, 1910, Doctor Brannon practiced in Winneconne, Wis, for a number of years. He was a member of the American Medical Society of Vienna, Austria, the American Institute of Hypnosis, and the American Academy of Family Physicians. Surviving are his widow, Margaret; and two daughters, Jessica and Amanda.

Donald W Bower, MD, 59, Madison, died May 8, 1981 in Madison. Born July 6, 1921 in Detroit, Mich, Doctor Bower graduated from Wayne State Medical School and served his internship and residency at the Detroit Receiv-

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**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*, IMS America Ltd., September 1980.

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Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
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ing Hospital in Michigan. He served in the United States Army during World War II. Doctor Bower practiced in Lincoln Park, Michigan for 35 years before retiring to Madison in 1980. Surviving are his daughter, Donna Bower McDowell, Madison; and two sons, John M, Santa Cruz, Calif, and John Foote of Charlotte, North Carolina.

Robert A Turcott, MD, 66, Madison, died May 8, 1981 in Madison. Born Oct 31, 1914 in Boyne City, Mich, Doctor Turcott graduated from Marquette University School of Medicine and served his internship at Misericordia Hospital in Milwaukee. He practiced in Lake Mills for 12 years and served in the United States Army for three years. He was associated with the Veterans Administration Hospital, Wood, and Ann Arbor Veterans Hospital, Mich, from 1963 until his retirement in 1976. Surviving are his widow, Ruth; two daughters, Jill and Mary, Milwaukee; four sons, Robert, Lake Mills; Richard, Milwaukee; and John and Brian of Madison.

Robert S Haukohl, MD, 65, former president of The Medical Society of Milwaukee County, died May 9, 1981 in Tampa, Fla. Doctor Haukohl graduated from Marquette University School of Medicine and served his internship at Milwaukee County General Hospital. His residency was completed at St Joseph's Hospital, Milwaukee. Doctor Haukohl served in the United States Army Medical Corps from 1941-45 during World War II. He was an associate professor of pathology at Marquette University Medical School; served as president of the Wisconsin Society of Pathologists from 1963-65; was president of The Medical Society of Milwaukee County in 1964; and also was director of the pathology department at Deaconess Hospital from 1947-67 when he moved to Florida. Surviving are his widow, Elizabeth; three sons, Robert, Brookfield; Mark, New York City; and Kurt of Houston, Tex.

John J Sevenants, MD, 66, LaCrosse, died May 15, 1981 in LaCrosse. Born Aug 15, 1914 in Marmarth, ND, Doctor Sevenants graduated from the University of Minnesota Medical School. He served with the United States Army Medical Corps for four and a half years during World War II before completing his residency at the University of Minnesota. Surviving are his widow, Betty; a daughter, Mrs William (Jean) Mueller, Houston, Tex; and a son, Frederick of DeSoto, Wis.

Joseph M Lubitz, MD, 70, Oconomowoc, died May 15, 1981 in Oconomowoc. Born July 1, 1910 in New York City, Doctor Lubitz graduated from the University of Munich Medical School in Germany in 1936. He served his internship at St Mary's Hospital, Milwaukee, and his residency at Milwaukee County General Hospital. In 1946 he joined the faculty of Marquette University School of Medicine (now the Medical College of Wisconsin) and served as chief of Laboratory Service

at the Veterans Administration Hospital, Wood, Wis. In 1962 he became Director of the Laboratory at Oconomowoc Memorial Hospital where he also served as chief-of-staff from 1977-1979. Doctor Lubitz served on the board of directors of Sacred Heart and DePaul Rehabilitation hospitals in Milwaukee. A former president of the Wisconsin Society of Pathologists, Doctor Lubitz served as chairman of the Commission on Governmental Affairs of the State Medical Society of Wisconsin, a post he had held for the past six years. In March 1981 the State Medical Society awarded him the "Council Award," the highest honor of the Society. Doctor Lubitz was the 45th recipient of the award which is given to those physicians who have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Surviving are his widow, Ina Maria; a daughter, Joan Grosz, Whitefish Bay; and a son, Peter of Takoma Park, Md.

Richard A Henry, MD, 33, Reedsburg, died May 17, 1981 in Reedsburg. Born July 1, 1947 in LaCrosse, Doctor Henry graduated from the University of Wisconsin Medical School in 1973 and served his internship and pathology residency at Madison General Hospital. He was on the medical staff of Reedsburg Memorial Hospital and was associated with the Physician Consultants in Pathology of Beaver Dam. Doctor Henry was a member of the Physicians Alliance Commission and the Commission on Public Information of the State Medical Society of Wisconsin. He also was a member of the International Academy of Pathologists, a member of the American Society of Clinical Pathologists, and a member of the College of American Pathologists. Surviving are his widow, Diane; a daughter, Erika Ann, and a son, Ricky.

Edgar M End, MD, 70, Wauwatosa, died May 23, 1981 in Wauwatosa. Born Oct 15, 1910 in Milwaukee, Doctor End graduated from Marquette University School of Medicine, Milwaukee, and served his internship at Milwaukee County General Hospital. He had directed Milwaukee County's hyperbaric medicine service since 1940, and also was assistant clinical professor of environmental medicine at The Medical College of Wisconsin. Doctor End was known for his discovery that mixing oxygen with helium instead of nitrogen could allow deep sea diving at depths of up to 1,000 feet. He was a member of the Undersea Medical Society and received the Simon C Weisfeldt Memorial Award in Occupational and Environmental Medicine from the Medical College of Wisconsin. Surviving are his widow, Mary; his former wife, Audrey, Wauwatosa; a son, Kevin, Wauwatosa; seven daughters, Mrs Patrick (Eileen) Kolehouse, Oconomowoc; Kathy, Wauwatosa; Mrs Norbert (Maureen) Lochowitz, Elm Grove; Sheila, Minneapolis; Colleen, Grafton; Mary, Wauwatosa; and Laurie of Kent State University in Ohio. ■

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MSMC objects to editorial comment

MILWAUKEE: "Physicians should be no less immunue to editorial criticism than anyone else—but fairness dictates that such criticism be based on accurate data," Medical Society of Milwaukee County Executive Vice President Michael McManus wrote the *Milwaukee Sentinel* in June.

McManus objected to a May 30 editorial cartoon which contained a caricature of a shaggy looking physician with a medical bag stuffed with Medicaid dollars.

McManus said the cartoon depiction was "just plain intolerable" and proceeded to point out several key facts concerning physician reimbursement under Medicaid:

• Only 7% of the total Medicaid budget is paid for physicians' services.

• Medicaid reimburses physicians at substantially less than their usual fees. Physicians were the *ONLY* group who volunteered to forego a Medicaid rate increase last year and they expect only a 4.5% increase this year.

• The medical profession is proud of its continuing voluntary efforts to restrain fee increases in the private marketplace as well. The following comparisons come from the government's own Consumer Price Index:

	All Items	MD Fees
1978	9.0	8.1
1979	13.3	9.4
1980	12.4	11.0

The 1981 CPI shows that the increase in physicians' fees is just about level with the overall cost of living index.

POLK: At a recent meeting of the Polk County Medical Society, Mr Lew Whitmer, Scandia, Minn, presented a paper entitled "Alcoholism—The Family Disease." Mr Whitmer is director of the St Croix Valley Chemical Dependency Center.

POLK: The Polk County Medical Society, at a recent meeting, had as its guest speaker David Williams, MD, St Louis Park Medical Center, Minn. He presented a paper on "What's New in Antibiotics."

WINNEBAGO: Forty-three members and three guests were present at the Winnebago County Medical Society April meeting held in Oshkosh to hear Andrew Zweifler, MD, Professor of Internal Medicine and Director of the Hypertension Clinic at University Hospitals, University of Michigan, Ann Arbor, Mich. Doctor Zweifler presented a paper on "Current Trends in the Treatment of Hypertension." ■

WINNEBAGO: The Winnebago County Medical Society at its May meeting announced its new officers for the year 1981-82. They are MDs M James Simonson,* Oshkosh, president; Roy E Buck,* Neenah, secretary-treasurer and president-elect. Members of the Brown County Medical Society, MDs James R Mattson,* Kenneth R Kubsch,* Louis D Philipp,* and Jeremy R Green,* spoke on the paper entitled "One County Medical Society's Efforts to Promote Medical-Industrial Community Relations and Medical Cost Containments."

WINNEBAGO: At its June 4 meeting the Winnebago County Medical Society took an official position against the closed panel HMO concept. The motion passed without descending votes following a discussion of HMOs. An SMS Physicians Alliance field consultant, Kris Bjerstrom, gave an update report of legislative events as they relate to medicine. There were 33 members and two guests present. The next meeting will be held September 3. ■

NEWS YOU CAN USE

MATERNAL SMOKING BROCHURE AVAILABLE. Evidence keeps coming in of the ill effects of maternal smoking on the unborn infant. Now, a new study by a researcher at the University of Michigan, Ann Arbor, says that maternal smoking also substantially lowers the Apgar score. The study suggests that fetuses may be suffering from prenatal carbon monoxide poisoning. The physicians of the State Medical Society and, in particular, its Committee on Maternal and Child Health, have recognized this problem and are committed to informing women of the hazards of smoking for both baby and mother. SMS informs physicians that a mini-brochure, "Make Yours a Smokeless Pregnancy," is available for use with their patients. To order copies of this free brochure contact: SMS Communications Department, PO Box 1109, Madison, WI 53701.

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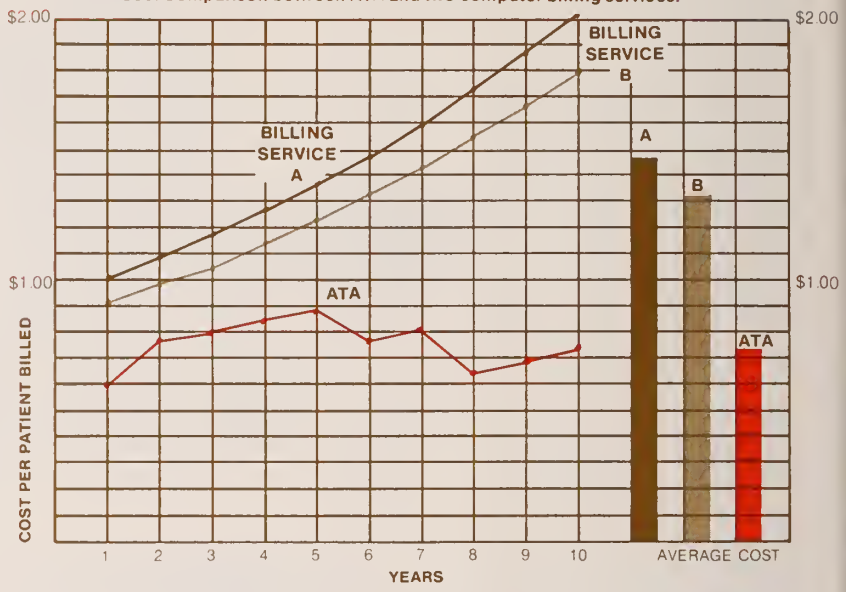
Cost Comparison between ATA and two computer billing services.



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Medical computer systems

American College of International Physicians, Inc will induct Alfonso de Guzman Taymayo, MD,* Sturgeon Bay, as a Regular Fellow in August at the Convocation of Fellows.

American College of Physicians recently announced the election of 286 new Fellows. Two physicians from Wisconsin, Sheldon R Braun, MD, Madison, and Maury B Berger, MD of Milwaukee, were formally inducted at the College's annual session held in Philadelphia, Pa.

American Academy of Pediatrics has announced plans to form a national coalition of medical specialty societies and child health groups which would mount a national campaign to promote the use of child care safety seats and seat belts. R Don Blim, MD, president of the Academy, called attention to the national problem of child vehicle safety. He said that the Academy's new "The First Ride. . .A Safe Ride" program seeks to have every newborn infant ride home from the hospital nursery in an approved child safety seat, and to use safety seats or seat belts for every ride afterwards. The Academy now plans to involve other medical and child health groups in this effort on a comprehensive, national level. The Academy also plans to mobilize physicians and other healthcare professionals, hospitals, governmental agencies, and community groups to promote the use of car seats and safety belts to children in a coordinated program at the national, state, and local levels.

The president of Dane County Medical Society in October 1980, Hubert V Moss, MD,* Madison, presented two checks totaling $7,000 to the American Red Cross, Dane County Chapter, for its Infant Care Safety Seat Program (KISS). The program was implemented through Madison hospitals and offered parents the opportunity to take their new baby home, safely in an approved car seat. The infant car seat loan program, which began last October in Dane County, still needs volunteers. Red Cross volunteers explain the program and demonstrate the use of car restraints to new mothers in Madison hospitals. For more information call Lynn Bliss, RN, Red Cross Nursing and Health Services Director, 255-0021.

Wisconsin Gastrointestinal Endoscopic Society has announced the following MDs as its new officers. They are Walter J Hogan, Milwaukee, president; Robert G Norfleet,* Marshfield, vice-president; and Joseph E Geenen,* Racine, as secretary-treasurer. ■

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Physician Briefs

*Physician members of State Medical Society of Wisconsin

Richard Kark, MD,* Eau Claire, recently joined the Midelfort Clinic's Department of Acute Illness. He previously was associated with Monona Grove Clinic at McFarland and Monona. Doctor Kark graduated from the Medical College of Wisconsin, Milwaukee, in 1975, and completed his family practice residency at St Mary's Hospital in Milwaukee.

James J Magnino, MD, formerly of Kenosha, recently joined the medical staff of the Wautoma Medical Clinic. Doctor Magnino graduated from the University of Wisconsin Medical School, Madison, and completed his internship and residency training at the University of Iowa in Iowa City.

Helen H Ahn, MD,* and **Jameel S Mubarak, MD,*** Tomah, recently joined the newly opened branch office of the Gundersen Clinic, Ltd in Tomah. Doctor Ahn graduated from Ewha Women's University Medical School in Seoul, Korea, and completed her internship and residency training in Seoul; Columbus, Ga; and Birmingham, Ala. She is on the medical staff at Tomah Memorial Hospital and also served as chief-of-staff of the hospital. Doctor Mubarak has practiced medicine in Tomah since 1947. He graduated from the Medical College of Wisconsin, Milwaukee, and completed his internship at Milwaukee Lutheran Hospital, and his residency training at St Luke's Hospital and Milwaukee Children's Hospital.

Timothy J Lindgren, MD, Park Falls, recently was named a diplomate of the American Board of Family Practice. The two-day written examination is designed to prove the physician's ability in the areas of internal medicine, surgery, obstetrics, gynecology, pediatrics, psychiatry, and community medicine. To quality for the examination a physician must have completed three years of residency training in family practice.

Tieu Minh Thu, MD, Cudahy, recently was appointed assistant professor of pathology at the Medical College of Wisconsin. Doctor Thu came to Wisconsin in 1975 as research assistant at Wood Veterans Administration Center's electron microscopy laboratory, and in 1976 he taught anatomy at MCW. Doctor Thu graduated from the University of Saigon, Vietnam, in 1966.

Edward Glazier, MD,* Waupaca, has joined the medical staff of the Marion Clinic in Marion. A graduate from George Washington University Medical School, he served his internship at Decatur, Illinois County Hospital. Doctor Glazier practiced in The Philippines, South and Central America, and in Waukesha. He joined the medical staff of the Wisconsin Veterans Home in King in 1975. Also an ordained Protestant minister, Doctor Glazier is president of the Waupaca County Chapter, the International Fellowship of Christian Physicians and the International Fellowship of Jesus Christ, of which he is a coordinator.

Dean T Stueland, MD,* recently joined the medical staff of the Marshfield Clinic. Doctor Stueland graduated from the University of Wisconsin Medical School, Madison, and completed his residency in internal medicine in Marshfield. He previously served as emergency room physician at Riverview Hospital in Wisconsin Rapids.

John C Zeldenrust, MD, formerly of Defiance, Ohio, recently joined Doctors Clinic Ltd of Two Rivers. He graduated from the University of Michigan School of Medicine and served his internship at St Joseph Hospital, Denver, Colo. Doctor Zeldenrust served his residency at the University of Colorado Medical Center, Denver. He is Board certified by the American Board of Surgery.

Cynthia P Northup, MD, Sheboygan, recently became a member of the Sheboygan Clinic in the Department of Family Practice. Doctor Northup graduated from Northwestern University Medical School in 1974. Her internship and residency were completed at the State University of New York, Buffalo, in Deaconess Hospital Family Practice Residency Training Program. Doctor Northup was in private practice in Lockport, NY, from 1977-1979. Her husband, Cole S Northup, MD,* an orthopedic surgeon, also is a member of the medical staff of the Sheboygan Clinic.

Robert W Krieger, MD,* Hartland, recently was elected a fellow in the American Academy of Pediatrics. Doctor Krieger is a clinical instructor in pediatrics at the Medical College of Wisconsin, Milwaukee, clinical instructor at Milwaukee Children's Hospital, and on the active medical staff of Oconomowoc Memorial Hospital in Oconomowoc.

John P Grausz, MD, Shorewood, recently was honored with the Helen F Callon—Thomas E Leonard Award from the Wisconsin Association for Perinatal Care. Doctor Grausz is associate professor of pediatrics at the Medical College of Wisconsin and director of neonatology at the Milwaukee County Medical Complex.

Michael C Gordon, MD,* formerly of Madison, has become associated with the Anderson Alcoholic Rehabilitation Hospital in Janesville. Involved in the treatment of alcoholism for a number of years, Doctor Gordon is a member of the Committee on Alcohol and Other Drug Abuse of the State Medical Society of Wisconsin and also the American Medical Society on Alcoholism, a branch of the National Council on Alcoholism.

Everett A Beguin Jr, MD,* LaCrosse, associated with the Department of Obstetrics-Gynecology at the Gundersen Clinic, has become the 1981-82 president of the Wisconsin Association of Perinatal Care. Doctor Beguin, who has subspecialty training in perinatology, was president-elect and has been chairman of the organization's program committee for the past two years. ■

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University of Wisconsin Department of Radiology, Madison, recently named as its chairman, Joseph F Sackett, MD.* Doctor Sackett graduated from Tulane University in 1966 and has been a member of the UW Medical School faculty since 1974. He has written and co-authored more than 35 publications in the field of neuroradiology, including a textbook on radiology techniques for the spinal cord. Among other awards, Doctor Sackett has received a $96,000 grant from Winthrop Laboratories for research, teaching, and installation of new x-ray equipment.

The United States Pharmacopeial Convention, Inc (USP) recently announced a new panel of experts in the field of nursing practice to work with them in its drug-use information development programs. The USP Advisory Panel on Nursing Practice is one of the 26 expert advisory panels which provide input into the publications of the USP Drug Information Division. In addition, the advisory panel provides advice to the USP Committee of Revision for the development of the official standards of strength, quality, purity, packaging, and labeling. The Nursing Practice Advisory Panel members were selected by its chairman, Barbara K Redman, PhD, who is Patient Health Education Coordinator, Veterans Administration Central Office, Washington, DC. Doctor Redman has chosen as one of the members of the panel, Mecca S Cranley, RN, PhD, Assistant Professor, Perinatal Nursing, Center for Health Sciences, University of Wisconsin-Madison, School of Nursing, Madison. During the five-year term, the Panel will develop, review, and revise drug monographs for the annual editions of *USP Dispensing Information* and *About Your Medicines,* a new, lay language drug-use handbook.

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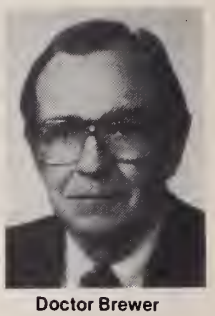
The Medical College of Wisconsin recently presented Bruce J Brewer, MD,* Milwaukee, professor and chairman of orthopaedic surgery at MCW, with the "Distinguished Service Award." Doctor Brewer, a 1940 alumnus, has been on the MCW faculty for more than 30 years. He currently is president of the Clinical Orthopaedic Society. Since 1972, he has served as a Board Program Surveyor for the Residency Review Committee of the American Medical Association as a representative of the American Board of Orthopaedic Surgery. Honorary Doctor of Science degrees were presented to Thomas E Starzl, MD, PhD, professor of surgery at the University of Pittsburgh and Howard M Temin, PhD, professor of oncology at the McCardle Laboratory, University of Wisconsin, Madison. David Carley, PhD, president of the National Association of Public Television Stations received an honorary Doctor of Law Degree.



Doctor Brewer

University of Wisconsin Alumni Association, has named Burton M Zimmerman, MD,* president of the Association. A family practitioner at Mount Sinai Medical Center, Milwaukee, Doctor Zimmerman graduated in 1943. Wilbert W Wiviott, MD,* Milwaukee, was elected president-elect. Doctor Wiviott is a 1957 graduate and past president of the Wisconsin Society of Plastic Surgeons. George W Kindschi, MD,* Monroe, was elected to a three-year term on the board of directors. A member of the 1968 graduating class, Doctor Kindschi is a member of the Department of Pathology at The Monroe Clinic.

Sacred Heart Rehabilitation Hospital's Awards Committee, Milwaukee, recently selected Robert and Dorothy DeBolt, Oakland, Ca, as recipients of the 1981 Tau Award. The announcement was made by Ferdinand Leyva, administrator of the hospital. The Tau Award is given annually to an individual or group for outstanding service and commitment to the disabled. The DeBolts, who have been described as virtual miracle workers, have adopted 14 of their 20 children. They describe the children as physically or emotionally "challenged"; others would refer to them as disabled. The children are of a variety of races and disabilities ranging from Vietnamese children, orphaned and severely wounded in the war, to a twelve-year old black child born without arms and legs. ■

Medical Assistants

JULY 1981

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Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

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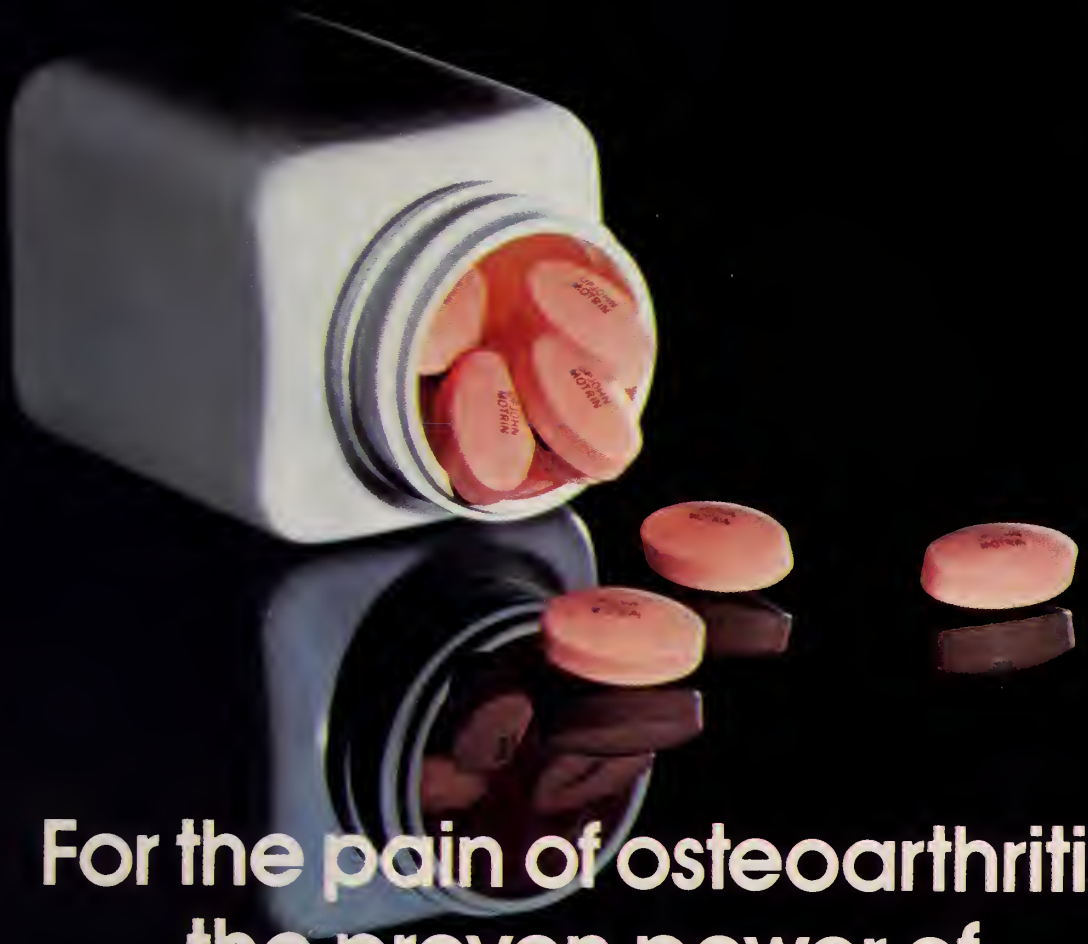

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Warnings: Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. *Motrin* should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If *Motrin* must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity characterized by papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin*.

Precautions: **Blurred and/or diminished vision,** scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* and the patient should have an ophthalmologic examination, including central visual fields and color vision testing. **Fluid retention and edema** have been associated with *Motrin;* use with caution in patients with a history of cardiac decompensation or hypertension. *Motrin* is excreted mainly by the kidneys. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* safety in patients with chronic renal failure have not been done. *Motrin* can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy. Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema. To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* is added. The antipyretic, anti-inflammatory activity of *Motrin* may mask inflammation and fever.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal, of which one or more occurred in 4% to 16% of the patients.

Incidence Greater Than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence Less Than 1%—Probable Causal Relationship*

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence Less Than 1%—Causal Relationship Unknown*

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

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Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

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General and vascular surgeon, FACS, Board certified, highly qualified, with several years of practice, would like to join an individual or group with an established practice in metropolitan Milwaukee area. Contact Dept 493 in care of the Journal. 7/81*

Fifty-physician multispecialty clinic in West Central Wisconsin wants family practitioner for nearby satellite office, allergist, cardiologist (non-invasive), neonatologist, orthopedic surgeon, otolaryngologist, psychiatrist, pulmonary disease internist. Excellent cultural, education, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepsen, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54702 or call 715/839-5266. 7-9/81

The Wisconsin Veterans Home has a current vacancy for a staff physician. The Home, located in the heart of Central Wisconsin's premier vacation area, is a nationally recognized extended care facility for Wisconsin veterans and their dependents. In our rural setting we offer not only a challenging medical opportunity, but also the opportunity to live and play with your family in an area that is untroubled by problems present in an urban environment. The starting salary is competitive (starting to $67,000), depending on training, experience and certification, and is enhanced by a comprehensive fringe benefit program. Fringe benefits include: fully vested retirement program; liberal vacation and sick leave policies; extensive insurance benefits; paid malpractice insurance, and other benefits. If you are interested in further information please contact John Peters, Personnel Manager, Wisconsin Veterans Home, King, Wis 54946. An Equal Opportunity Affirmative Action Employer. 7/81

Board certified or eligible family practitioners, OB-GYN and surgeon wanted to join expanding multispecialty group located in South Central Wisconsin near major metropolitan area. Excellent salary structure and benefits first year with options thereafter. Interested physicians inquire immediately. All requests to be answered immediately and in confidence. Write Dept 488 in care of the Journal. 5tfn/81

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

8-12/80,1-7/81

Physicians Exchange

continued

Family Practitioner to join a 50-physician multispecialty group with an 11-man Family Practice Department. Primary responsibilities would involve coverage of satellite and other physician offices for absences. Obstetrics, hospital patients and after-hour calls optional. An unusual opportunity for a physician who prefers to avoid continuing care responsibilities. Guaranteed salary and excellent fringe benefits. Send CV to: Director of Professional Affairs, Skemp-Grandview-LaCrosse Clinic, Ltd, 815 S 10th St, LaCrosse, Wis 54601. 7/81

Family Practitioner or Internist to join 3-man group in Northern Wisconsin locale offering year-round outdoor activities. Clinic located close to 70-bed general hospital. Partnership first year. Attractive fringe benefits. Contact N L Bugarin, MD, Family Clinic, SC, 221 E Washington Ave, Tomahawk, Wis 54487; ph 715/453-2147. 7tfn/81

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties. *Anesthesiology, Family Practice, Hematology/Oncology, Neurology* and *Otolaryngology.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 7tfn/81

Racine Medical Clinic, multispecialty group of 22 physicians has a practice association for internist. The clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406. Phone 414/886-5000. 5tfn/81

Wanted. Board certified or eligible oncologist to practice in conjunction with an 8-member medical department in a 22-member multispecialty group. Present sub-specialties: gastroenterology and cardiology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Obstetrician-Gynecologist, Board certified or eligible, to join 13-physician multispecialty group in metropolitan Milwaukee. Community of 31,000 offers excellent cultural, educational, and recreational facilities. Guaranteed first-year salary plus incentive. Ownership and comprehensive fringe benefit program available after one year. Send CV or inquiries to: PO Box 97, Butler, Wis 53007. 7tfn/81

Family Practice Physician sought for affluent small town with excellent social, retail, and educational resources. Easy access to year-round outdoor activities and to Chicago and Rockford for social and professional opportunities. For the family man with ambition for a successful practice.

Contact: Harvey Pettry, Administrator
Highland Hospital
1625 S State St
Belvidere, IL 61008
815/547-5441 6-8/81

Orthopaedic surgeon. Board eligible or certified to join established orthopaedist in central Wisconsin community of 18,000 with 36,000 service area. Progressive practice. Modern, well-equipped, 126-bed hospital. Excellent schools. Ideal family community. Salary open. Contact Dr McDonough, Riverview Hospital Medical Office Building, 400 Dewey St, Wisconsin Rapids, Wis 54494. Phone 715/421-5257 office; 715/325-2421 home. 7-9/81

Family Practice. General Clinic—Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 23-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 2tfn/81

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

Family Practice. Physician needed to join three Board certified family practitioners and one general surgeon. New clinic building adjacent to hospital in beautiful northwestern Wisconsin. Call is shared with other family practitioners in community. Contact Jean Chamberlain, Administrator, Spooner Clinic Ltd, 707 Ash, Spooner, Wis 54801. Phone 715/635-2151. 5-7/81

Position now available in the Department of Internal Medicine for physician with subspecialty interest. Fifty-person multispecialty clinic in ideal location in Southern Wisconsin. Contact R E Hassler, MD, The Monroe Clinic, Monroe, WI 53566; ph 608/328-7000. 5-7/81

Practice opportunities for: *Opthalmologist, Neurologist, Psychiatrist, Family Practice (satellite locations). Internal Medicine w/subspecialty (except Gastroenterology).* Board eligible or board certified, to join 50-man multispecialty practice in southern Wisconsin, 45 minutes to Madison, two hours to Milwaukee. Perfect location for good family living. Contact: R E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566 or ph 608/328-7000. 7-9/81

Neurosurgeon. Board eligible or Board certified to join multispecialty group practice in southern Wisconsin. Excellent facilities and equipment. Monday through Friday office hours plus routine call schedule. $70,000 base salary. Submit resume to Job Service Wisconsin, 1220 16th Ave, PO Box 311, Monroe Wis 53566. 7/81

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive, Madison, Wisconsin 53716
Phone: (608) 222-2927 *Licensed Employment Agency*

Wisconsin—26 physician incorporated multispecialty group on the south shore of Lake Winnebago needs a fourth pediatrician. Guaranteed salary with full shareholder status available after one year. Send CV to Kirk A Veit, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. p5-7/81

Internist wanted to join a 14-physician multispecialty group in one of northern Wisconsin's finest recreation areas. Modern 109-bed hospital. Excellent professional and personal opportunity. Contact Dr J Wiesner, Lakeland Medical Associates Ltd, Box 549, Woodruff, Wis 54568 or call 715/356-3292. 5tfn/81

Duke trained general psychiatrist with strong interest in psychotherapy wishes to relocate in midwest (Wisconsin). Board certified. Contact James L Gallagher, MD, 2219 Mont Haven Dr, Durham, NC 27712. Phone 919/383-4477 (home); 919/417-3487 (office). 5-7/81

Emergency Medicine Opportunities. Directorship and clinical positions available in the greater Milwaukee area. Excellent income, paid malpractice insurance, and flexible scheduling provided. For details, send credentials in confidence to Michelle Grimm, 970 Executive Parkway, St Louis, MO 63141; or call toll-free 1/800-325-3982. 5-8/81

Ophthalmologist to join the Wilkinson Clinic, SC, a multispecialty group of 16 physicians located in lake country between Milwaukee/Madison. Excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: David O Ulery, MD, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 7tfn/81

Wanted: Neurologist, Board certified or eligible, to join solo incorporated neurosurgeon in North Central Wisconsin. Send resume to: 425 Pine Ridge Blvd, Suite 301, Wausau, Wis 54401. 7-8/81

Two Family Practice Physicians sought to assume a fully operational practice in a community 30 miles north of Madison, Wisconsin. New clinic facility. Income guaranteed. Physician back-up available. Board certified or eligible preferred. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 5tfn/81

Milwaukee Internal Medicine Group wishes to share office space with any medical specialty in its well-equipped satellite office. Contact: Administrator, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 7-9/81

CompHealth—Locum Tenens. Physicians covering physicians, nationwide, all specialties. We provide cost-effective quality care. Call us day or night. T C Kolff, MD, President, CompHealth, 175 W 200 S, Salt Lake City, Utah 84101; ph 801/532-1200. p7-10/81

Marinette, Wisconsin needs a neurologist, otolaryngologist, second orthopedist, and obstetricians. Office space available. Please contact Kenneth H Yuska, MD, phone 715/732-1746. 7-8/81

Emergency Physicians. Full-time openings for ER physicians with group serving hospitals in Manitowoc, Sheboygan, Wisconsin Rapids, Shawano, Oconto Falls, and other cities. Excellent starting salaries, flexible schedules. Must be willing to relocate to area. Send CV to: Central States Emergency Physicians, PC, 1846 Hoffman St, Suite 101, Madison, Wis 53704 or ph 1/800-362-7366. 7-12/81

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Medical Facilities

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

Medical Office Building. Racine, Wisconsin. Northside, Highway 32, 3343 Douglas Ave. One story building. Lease occupancy available June 1. Off street parking. Phone 414/639-7223 or 414/878-4020 evenings. 6-8/81

Wanted. Used x-ray equipment, accessories, diathermy and ultrasonic units. Call 414/444-7125. 7-9/81

Real Estate

The Perfect Retreat. Outstanding year-round vacation home nestled on a secluded bay in the midst of the northwoods of Michigan upper peninsula. This custom designed home of rough sawn cedar has 12 ft cathedral ceilings, 3 bedrooms, 2½ baths, 3 fireplaces, sauna, and 50 ft deck overlooking Portage Lakes Torch Bay. The 100-foot lake front property includes adjacent guest house with fireplace, deck, and 2-car garage. 15 minutes from Houghton-Hancock Jet Airport, downhill ski facilities and Lake Superior. Furnished if desired. Call 513/871-7888 or 871-0632 or write Len Koppana, 3565 Bayard Drive, Cincinnati, Ohio 45208. 6-7/81

Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Profile of the Residency Trained Family Physician in the United States. Editor, John P Geyman, MD. 1981. Appleton-Century-Crofts, 292 Madison Ave, New York, NY 10017. Pp 68. Price: $12.00.

The Future of Pharmaceuticals: The Changing Environment for New Drugs. By Clement Bezold, PhD. 1981. Institute for Alternative Futures, 1624 Crescent Place, NW, Washington, DC 20009. Pp 142.

The Physician and Sportsmedicine Guide to Running. By Allan J Ryan, MD, 1980. McGraw-Hill Book Co., 1221 Avenue of the Americas, New York, NY 10020. ■

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1980 through Aug 31, 1981.

WISCONSIN

AUGUST 2-7, 1981: *Perspectives in Anesthesiology,* Tucson Hospital Education Program, The Abbey on Lake Geneva, Fontana.

AUGUST 7-8, 1981: *Common Management Decisions in Medicine,* University of Wisconsin Memorial Union, Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Medicine; and University of Wisconsin-Extension, Department of Continuing Medical Education. Approved credit Category 1 AMA, AAFP, and AOA. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

AUGUST 24-25, 1981: *Uses and Abuses of Antibiotics in Clinical Practice,* Heidel House Resort, Green Lake. Sponsored by Berlin Memorial Hospital. Info: Linda E Nevers, CME Coordinator, Berlin Memorial Hospital, 225 Memorial Dr, Berlin, Wis 54923. Phone: 414/361-1313.

SEPTEMBER 8, 1981: Wisconsin State Medical Golf Association's Fall Tournament and Annual Meeting, Merrill Hills Country Club, Waukesha. Tee-off times start at 9:00 am until 1:30 pm. Info: Ronald Oschman, Secretary, WSMGA, 401 West Michigan, Milwaukee, Wis 53201; ph 414/266-6151.

SEPTEMBER 11-12, 1981: *Seminars in Pediatrics,* University of Wisconsin Clinical Science Center, Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Pediatrics; and University of Wisconsin-Extension, Department of Continuing Medical Education. AMA credit Category 1; AAFP pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

SEPTEMBER 17-19, 1981: *Infectious Diseases,* Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Medicine; and University of Wisconsin-Extension, Department of Continuing Medical Education. AMA Credit Category 1; AAFP and AOA credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

SEPTEMBER 18-20, 1981: Fall Meeting, Wisconsin Society of Anesthesiologists, Lake Lawn Lodge, Delavan.

SEPTEMBER 23-26, 1981: *6th Annual Nuclear Cardiology Symposium,* Milwaukee. Sponsored by Mount Sinai Medical Center, Milwaukee; and University of Wisconsin-Extension, Department of Continuing Medical Education; University of Wisconsin School of Medicine, Milwaukee Clinical Campus, Cardiovascular Disease Program; American Heart Association; and Society of Nuclear Medicine. AMA Category 1; UW Continuing Medical Education Units; VOICE. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

MIDWEST CANCER SEMINAR
Madison, Wisconsin
September 17-19, 1981

For physicians from the midwestern states who are engaged in primary care and oncology-related specialties.

Sponsored by the Wisconsin Clinical Cancer Center-University of Wisconsin-Madison.

Objectives: To bring to the practicing physician current knowledge regarding screening, diagnosis and management of major malignancies.

Program: Sixteen visiting faculty from throughout the United States and Europe will participate.

WCCC Fall Cancer Conference: Saturday morning, September 19. UW-UCLA football game in afternoon.

Location: All sessions will be held at the Concourse Hotel.

CME Credit: 18 credit hours

Information: Contact Paul C Tracy, MD, telephone: 608/263-3455 or 263-2855.

7/81

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
1992—Apr 23-25	

Meeting days will be Thursday, Friday, Saturday; the first session of the House of Delegates will convene on Thursday, the second on Friday, the third on Saturday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

SEPTEMBER 25-26, 1981: *The High-Risk Patient with Dental Problems,* Madison. Sponsored by University of Wisconsin-Extension, Department of Continuing Medical Education; University of Wisconsin, School of Medicine; and Wisconsin Chapter, Academy of General Dentistry. Credit: University of Wisconsin Continuing Education Hours; Fellowship and Mastership credit, Academy of General Dentistry. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

OCTOBER 14-17, 1981: *Wellness and Cardiovascular Health Symposium,* in celebration of the 10th anniversary of the LaCrosse Exercise Program. Involving: Adult Fitness, Patient Education, School Fitness, Exercise Testing, Community Fitness, Cardiac Rehabilitation, Exercise Physiology, Industrial Fitness, Sports Medicine, and Wellness. Inquiries: LaCrosse Exercise Program-Workshop Unit, Mitchell Hall, UW-L, LaCrosse, Wis 54601 (ph 608/785-8686).

OCTOBER 9-10, 1981: Wisconsin Chapter, American College of Emergency Medicine, Pfister Hotel, Milwaukee.

NOVEMBER 13, 1981: Wisconsin Orthopaedic Society, Olympia Resort, Oconomowoc.

FEBRUARY 25-28, 1982: Wisconsin Psychiatric Association, Lake Lawn Lodge, Lake Delavan.

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1981-1982

Wisconsin Society of Anesthesiologists, Sept 18-20, 1981, Lake Lawn, Lake Delavan

Wisconsin Dermatological Society, Oct 24, 1981, Froedtert Memorial Lutheran Hospital, Milwaukee; and Feb 27, 1982, University of Wisconsin Center for Health Sciences, Madison

Wisconsin Neurosurgical Society, September 18-19, 1981, Madison

Wisconsin Society of Obstetrics & Gynecology, June 11-13, 1981, Telemark Lodge, Cable

Wisconsin Section, American College of Obstetricians & Gynecologists (District VI), Sept 9-12, 1981, Minneapolis, Minn

Wisconsin Society of Otolaryngology, Aug 29-30, 1981, Maxwelton Braes Resort, Baileys Harbor

Wisconsin Society of Pathologists, October 1981

Wisconsin Chapter, American Academy of Pediatrics, Sept 11-12, 1981, University of Wisconsin Clinical Science Center, Madison

Wisconsin Radiological Society, Oct 10, 1981, Concourse Hotel, Madison

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SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, May 13-15, 1982, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

MIDWEST

AUGUST 20-23, 1981 (Illinois): Sixth annual convention, American College of International Physicians, Inc, Holiday Inn, Lake Shore Drive, Chicago.

AUGUST 29-SEPTEMBER 12, 1981 (Illinois): Illinois State medical Society announces new travel program, an *Alaskan Cruise,* aboard Sitmar Cruises' elegant TSS FAIRSEA, sailing from San Francisco. Arrangements made for a CME seminar. Flights from Madison and Milwaukee to San Francisco at cost of $175. Info: Illinois State Medical Society, 55 East Monroe St, Suite 3510, Chicago, Ill 60603 (ph 312/782-1654). g5-7/81

SEPTEMBER 10-11, 1981: 41st Annual AMA Congress on Occupational Health/Central States Occupational Medical Association Fall Seminar. This two-day meeting will include practical clinical information on respiratory problems, pain clinics, cardiac problems and arthritis as they relate to the working population. It will be held at the Pfister Hotel in Milwaukee, Wis. Fee: $60 physicians, $40 allied health professionals. Info: Dept of Environmental Public and Occupational Health, American Medical Association, 535 N Dearborn St, Chicago, IL 60610.

SEPTEMBER 18-19, 1981 (Chicago, IL): AMA Hospital Medical Staff Leadership Seminar, Drake Hotel, Chicago. Info: Dept of Hospitals & Health Facilities, AMA, 535 N Dearborn St, Chicago, IL 60610; ph 312/751-6656. (See ad elsewhere in this section.)

Ninth Annual Illinois Congress on Continuing Medical Education

September 11-12, 1981

Friday, Sept 11, 7:45 pm to Saturday, Sept 12, 5:00 pm

Oak Brook Hyatt Hotel, Spring & Harger Roads

Oak Brook, Illinois

How Physicians Learn: Effective Methods in CME

This year's Congress, sponsored by the Illinois Council on Continuing Medical Education is the second of a four-year program cycle presenting all the fundamentals of CME planning. The 1981 program focuses on effective learning methods as well as skill in selecting methods likely to achieve specific CME Program Goals and Learning Objectives.

Highlighting this year's program will be *Howard S Barrows, MD,* Associate Dean/Education Affairs, Southern Illinois University School of Medicine, known internationally for his work in *problem-solving* and *simulations* in medical education.

Most of the Congress consists of small-group workshops, such as: Matching Methods to Needs, Teaching with Technology, Self-Directed Learning Techniques, Do's and Don'ts of Didactics, Medical Audit as a Learning Method. There also will be a special workshop for non-physician CME Coordinators.

For additional information, write or call the **Illinois Council/CME, 55 E Monroe, Suite 3510, Chicago, Illinois 60603 (ph 312/236-6110).**

MIDWEST (cont)

SEPTEMBER 25-27, 1981 (Indiana): *Second National Seminar on Community Cancer Care,* Hyatt Regency, Indianapolis. Sponsored by the Clinical Oncology Center and the Graduate Medical Center at the Methodist Hospital of Indiana, Inc. Info: Office of Continuing Medical Education, Methodist Hospital of Indiana, Inc, 1604 N Capitol Ave, Indianapolis, Ind 46204 (ph 317/924-8288). g5-8/81

OCTOBER 1-3, 1981 (Nebraska): Nebraska Medical Association Fall Session, Lincoln Hilton Hotel, Lincoln.

OTHERS

AUGUST 7-9, 1981 (West Virginia): *Medical staff issues and the practicing physician* seminar by JCAH, at The Greenbrier, White Sulphur Springs, W VA 24986 (phone 304/536-1110). Sponsor: West Virginia Hospital Research and Education Foundation, Inc.

AUGUST 10-11, 1981 (Washington, DC): *Antibiotic Review —1981,* Sheraton Washington Hotel, Washington, DC. Contact: Sandy McMillan, 67 Peachtree Park Dr, Suite 221-D, Atlanta, GA 30309. g6-7/81

AUG 22-SEPT 5, 1981 (Mediterranean): Fourteen-day cruise, departs Venice, Italy, and visiting Egypt, Israel, Turkey, and Yugoslavia. Approved 23 credit hours of Category I of AMA-PRA. Info: International Conferences, Suite C, 189 Lodge Ave, Huntington Station, NY 11746. Phone: 516/549-0869.

25th ANNUAL MEETING
American Association of Medical Assistants, Inc
SEPTEMBER 19-26, 1981
Hyatt Regency Hotel—Milwaukee
Host: Wisconsin Society-AAMAI
Theme: *Today's silver—tomorrow's gold*

Welcome party: Sunday evening, September 20, to share a bit of Wisconsin "gemutlichkeit" in a beer garden atmosphere

Official convention opening: Monday evening, September 21, with opening session of House of Delegates

Formal dinner: Wednesday evening, September 23, with awarding of certification pins and certificates to those who have successfully completed the national Certification Examination this past year.

Many interesting educational sessions and workshops throughout the week, along with organizational information and meetings

Between times there will be exhibits from many professional groups to visit, and the Arts and Crafts from many members to view

Inaugural banquet: Friday, September 25, when presidents of all the State Societies are introduced in the Parade of Presidents, highlighting the past 25 years, and new officers installed

General Chairman: Alice Budny
Vice Chairman: Carol Jean Beaver, RT

For registration blanks, write: American Association of Medical Assistants, Inc, One East Wacker Drive, Suite 2110, Chicago, Illinois 60601; or phone: (312) 944-2722

OCTOBER 17-21, 1981 (Louisiana): Annual Meeting, American Society of Anesthesiologists, New Orleans. Info: ASA, 515 Busse Highway, Park Ridge, Illinois 60068 (ph 312/825-5586).

OCTOBER 23-25, 1981 (Florida): *Medical staff issues and the practicing physician* seminar by JCAH, at Innisbrook, Tarpon Springs, FL. Registrar: Charlotte Wells, Florida Hospital Association, PO Box 6905, Orlando, FL 32853 (phone: 305/841-6230).

OCTOBER 31-NOVEMBER 5, 1981 (New Orleans, La): American Academy of Pediatrics 1981 Annual Meeting, New Orleans, La. Info: American Academy of Pediatrics, PO Box 1034, 1801 Hinman Ave, Evanston, Ill 60204.

NOVEMBER 6-9, 1981 (Nevada): *Medical staff issues and the practicing physician* seminar by JCAH, at Las Vegas, Nev. Registrar: Julie Efaw, Joint Commission on Accreditation of Hospitals, 875 N Michigan Ave, Chicago, IL 60611 (phone: 312/642-6061).

HEALTH CARE COST CONTAINMENT SEMINAR
October 12-14, 1982—Palm Springs, California—Spa Hotel

First such seminar to be held by the International Foundation of Employee Benefit Plans, John L Watts, president.

Purpose is to give representatives of employee hospital-medical benefit plans information and insight needed to plan and implement effective cost containment programs.

An overview of the US health delivery system will kick off the three-day program, followed by presentations on health care costs and the role of health planning; the position of the Reagan Administration; cost containment through plan design; cost containment through administration; cost savings and benefits of alcoholism, drug, and other special programs, and the future of benefit plans.

Workshops, panel discussions, open forums and a featured luncheon speaker will also be parts of the seminar. Speakers will be professionals in the benefits, insurance, and health service provider fields.

Registration fee for Foundation members and nonmembers alike will be $360 each.

More information may be obtained by writing or telephoning the International Foundation of Employee Benefit Plans, PO Box 69, Brookfield, Wisconsin 53005. Telephone 414/786-6700.

SNOWMASS/VAIL "MEP" SKI SEMINAR
On Management Enrichment for the Health Professional

Ski Snowmass, Colorado the week of December 19, 1981 or the week of March 20, 1982; or ski Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Seminars comply with IRS rules to make trip expenses deductible for doctor and spouse. For brochure and lodging information contact: MEP, An Education Corporation, 906 Cooper Ave, Glenwood Springs, Colorado 81601; or call 800/525-3402. 6-9/81

NOVEMBER 20-22, 1981 (Texas): *Medical staff issues and* the practicing physician seminar by JCAH, at Lakeway Inn, Austin, Tex. Info: Julie Efaw, JCAH Headquarters, 875 N Michigan Ave, Chicago, IL 60611 (phone: 312/642-6061, ext 353).

FEBRUARY 27-MARCH 6, 1982 (Captiva Island, Florida): *Rheumatology Seminar IV,* Captiva Island, Fla. 20 hours. For primary care physicians. Contact Minnesota Medical Association, Suite 400, 2221 University Ave, SE, Minneapolis, MN 55414, ph 612/378-1875. 7/81

AMA

DECEMBER 6-9, 1981: Interim AMA House of Delegates, Las Vegas, Nev.

AMA HOSPITAL MEDICAL STAFF LEADERSHIP SEMINAR

September 18-19, 1981, The Drake Hotel, Chicago, Illinois

This seminar is sponsored by the Department of Hospitals & Health Facilities of the American Medical Association. The seminar will explore the functions, duties, and responsibilities of the medical staff in its relationship to the hospital. It provides information fundamental to working and leading successfully in the physician-hospital environment.

Seminar will cover: Organizing the medical staff. Organizational responsibilities of the medical staff. The physician as a medical staff leader. Effective leadership. The art of negotiating. Accreditation clinic. Issue workshops. Quality assurance.

Speakers include: *Thomas G Baffes, MD; Jerry Clousson, JD; John P Hyden; Leroy R Levitt, MD; David L Schmidt; Nat T Winston Jr, MD.*

Info: Department of Hospitals & Health Facilities, American Medical Association, 535 N Dearborn St, Chicago, IL 60610; ph 312/751-6656.

JCAH education seminars

Medical staff issues and the practicing physician

Forum for physicians to discuss medicolegal concerns, medical staff organization, delineation of privileges and clinical reappointment, quality assurance requirements, and standards that direct the functions of the medical staff. Clinical faculty for these exciting and important seminars include several prominent practicing physicians, a JCAH physician surveyor, and an attorney.

Seminars will be offered in the following locations and on weekend dates that lend themselves to physicians' busy schedules:

August 7-9: The Greenbrier, White Sulphur Springs, West Virginia

October 23-25: Innisbrook, Tarpon Springs, Florida

November 6-9: Las Vegas, Nevada

November 20-22: Lakeway Inn, Austin, Texas

For further info: Julie Efaw, JCAH Headquarters, 875 N Michigan Ave, Chicago, IL 60611. Phone: 312/642-6061, ext 353.

As an organization accredited for continuing education, JCAH has determined that this CME activity meets the criteria for 11 credit hours in Category I of the Physician's Recognition Award of the AMA.

FEBRUARY 25-28, 1982: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl. ■

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For further information contact: Department of Foods and Nutrition, AMA, 535 N Dearborn St, Chicago, IL 60610.

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

CHANGE MADE IN LICENSE REGISTRATION PROCESS. Effective March 1, 1981, physicians no longer have to submit proof of continuing medical education credits to the Medical Examining Board for license registration purposes. Due to a change in the administrative rules of the Medical Examining Board, a physician in the second year of his biennial registration is required to sign a statement on the application for registration certifying that he/she has completed at least 30 hours of acceptable continuing medical education during the last biennium. ***Physicians should continue to maintain personal files of CME certification, however, as the Board at any time may require a physician to submit his/her evidence of compliance with the 30 credit rule to the Board for audit purposes.***

MEB WANTS REVIEW OF OUTPATIENT ABORTIONS. The State Medical Examining Board will ask SMS to establish a review procedure for ambulatory surgical center abortions. That review will include studying the credentials of physicians performing the abortions and establish a system to monitor the procedures. The Board made this decision at its June 18 meeting and has not yet formally requested the Medical Society to establish the review system.

INCREASES IN CORPORATE FILING FEES SUGGESTED. One of the smaller sections of the state's budget bill would increase the annual corporate filing fees for all Wisconsin corporations (including physician service corporations) from $10 to $50 per year. The Legislature's Joint Finance Committee has suggested that the five-fold increase be used to offset significant changes in the capital gains tax relief proposed by the same bill. This change is expected to generate several million from Wisconsin corporations.

FEDS EXTEND TIMETABLE FOR APPROPRIATENESS REVIEW. At the request of the Wisconsin Coalition of Health Systems Agencies, the Department of Health and Human Services has extended the state's review schedule for performing institution appropriateness reviews by one year. The HSAs will now have five instead of four years to complete the federally required cycle of reviews. The Department clearly recognizes that constraints imposed by recent funding cutbacks mean that HSAs and the state cannot possibly maintain the current vigorous pace of the program. As a practical matter, the Department's nod may serve as an indication that appropriateness review could become one of the first Health Planning programs eliminated completely.

PATIENT PACKAGE INSERT PROGRAM POSTPONED INDEFINITELY. The pilot program for patient package inserts (PPIs) for prescription drugs has been postponed by the Food and Drug Administration. The program, which had two phase effective dates of May 25 and July 2, would have required inserts for cimetidine, clofibrate, proposyphene, ampicillin, and phenytoin. The postponement does not affect currently mandated PPIs for oral contraceptives, estrogens, and progestins. In making the announcement, Federal Health and Human Services Secretary Richard Schweiker said the FDA will conduct a review of alternative means of providing information to patients about drugs and look at the cost effectiveness of the package insert approach.

OCHAMPUS ANNOUNCES CHANGE IN COVERAGE OF ALCOHOLISM TREATMENT. The Office of Civilian Health and Medical Program of the Uniformed Services announced a change which eliminates the requirement that an inpatient admission for alcohol detoxification immediately precede alcohol rehabilitation. The change will be retroactive for services provided on or after June 1, 1977. CHAMPUS beneficiaries who believe they are affected by this change or who have had a claim denied because of the previous requirement, should resubmit their claim to the CHAMPUS Fiscal Intermediary currently responsible for processing claims for the area in which the care was received. The time limit for resubmitting these claims is December 31, 1982. It is emphasized that the admission for treatment still requires physician referral and a diagnosis of alcoholism. In addition, the Fiscal Intermediary will review the claim to ensure that the following requirements are also met: 1) inpatient rehabilitative care not normally to exceed 21 days; (limit of three episodes, lifetime maximum), and 2) inpatient level of care must be medically necessary. Outpatient psychiatric treatment programs for alcoholism will continue to be covered, subject to the same review as other psychotherapy. ■

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WISCONSIN MEDICAL JOURNAL

AUGUST 1981

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- Medicaid practices
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AUG 25 1981

Examine Me.

During the past several years, I have heard my name mentioned in movies, on television and radio talk shows, and even at Senate subcommittee sessions. And I have seen it repeatedly in newspapers, magazines, and yes, best-sellers. Lately, whenever I see or hear the phrases "overmedicated society," "overuse," "misuse," and "abuse," my name is one of the reference points. Sometimes even *the* reference point.

These current issues, involving patient compliance or dependency-proneness, should be given careful scrutiny, for they may impede my overall therapeutic usefulness. As you know, a problem almost always involves improper usage. When I am prescribed and taken correctly, I can produce the effective relief for which I am intended.

Amid all this controversy, I ask you to reflect on and re-examine my merits. Think back on the patients in your practice who have been helped through your clinical counseling and prudent prescriptions for me. Consider your patients with heart problems, G.I. problems, and interpersonal problems who, when their anxiety was severe, have been able to benefit from the medication choice you've made. Recall how often you've heard, as a result, "Doctor, I don't know what I would have done without your help."

You and I can feel proud of what we've done together to reduce excessive anxiety and thus help patients to cope more successfully.

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diazepam/Roche

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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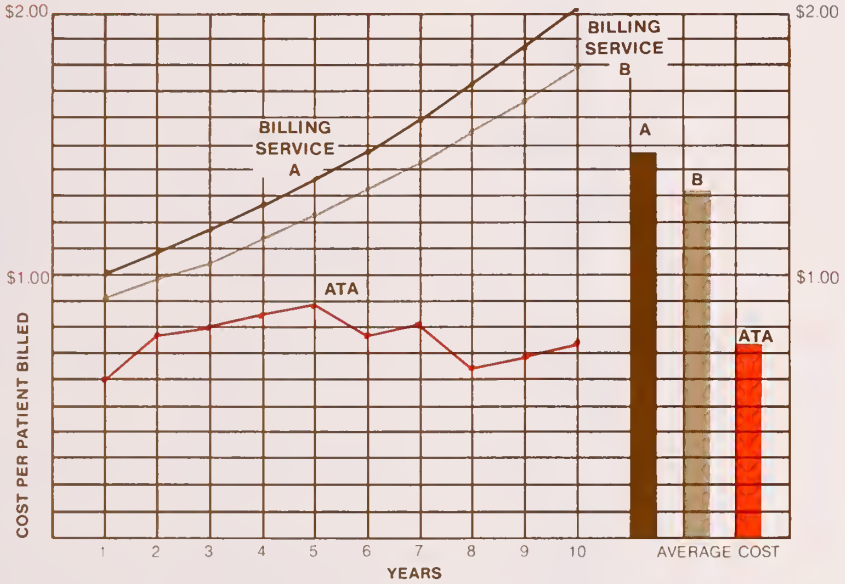

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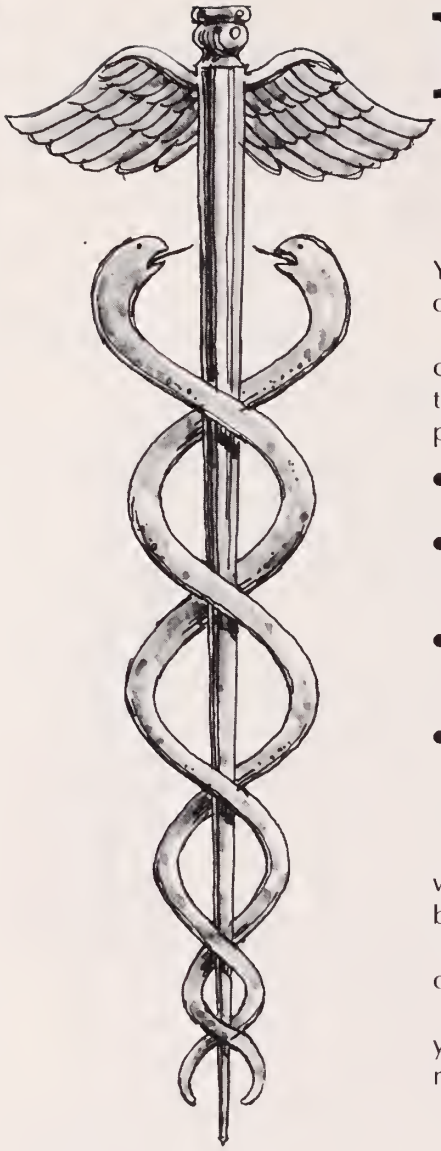

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President's Page

ALBERT J. MOTZEL JR, MD

The "rationing" of medical care PART I: How we got there

THE TOTAL DEMAND for, and therefore cost of, "medical care" for our society at this time is determined by a complex blend of circumstances:

1. The potential to diagnose accurately;
2. The ability to treat, either medically or surgically, those diagnosable problems;
3. The perception of individuals and society in general of the benefits of available diagnosis and treatment;
4. The availability of resources and personnel to direct the utilization of those diagnostic and therapeutic resources;
5. The competition of other perceived needs or desires of the individual for funds to purchase medical care;
6. The replacement of the competitive restraint on the purchase of medical care by "free" care purchased either by government or industry-purchased third-party payment for diagnostic and treatment services.

Let us consider what has occurred during the past 50 years in terms of changes in the above circumstances. Indeed, an unprecedented change has taken place in the first three factors delineated above.

The potential to diagnose accurately has expanded expotentially with continuing improvement in radiography including tomography, image amplification, relatively safe intravascular injection of dyes and the continuing refinements of computerized tomography, not to mention the development and refinement of nuclear, chemical, and biological studies.

Perhaps more importantly, the ability to treat those diagnosed problems is enormously more sophisticated with the advent of the array of antimicrobial agents, antibiotics, steroids, anesthetic agents, blood and blood components, surgical techniques, implantable prosthetic devices, antiinflammatory and antihypertensive agents, cobalt, linear accelerators, chemotherapeutic agents, and a myriad of other therapeutic modalities.

The above brief sampling of resources, unavailable during at least part of the lifetime of the majority of the present consumers of care, has convinced all but the most skeptical that if properly applied, there are real benefits to the individual and society from medical care available today. In a sense, medical care has become a victim of its own success.

There can be little doubt that the above developments are costly. Nor is there any doubt that their availability and perceived value have created a great demand for their application by individuals and society.

Two factors have combined to bring about the fourth circumstance—the availability of medical resources and personnel. Certainly the demand has stimulated the development and distribution of both increasingly sophisticated equipment and increased numbers of highly educated and trained personnel. But a new factor—an "artificial" factor—also surfaced. The Federal Government began to tamper with supply in a new and aggressive way; first by stimulating growth and development of facilities through the Hill-Burton Act, and then through numerous other programs, including the subsidization of medical schools and students, and the creation of programs to provide a variety of ancillary medical personnel and "limited practitioners." There would now be facilities and personnel available so that all of the diagnostic and therapeutic expertise available could be applied to all who desired it.

During this same period, many, including physicians, realizing the increasing cost of this more sophisticated care and unwilling to risk the deprivation of the many other necessities and luxuries available, opted for mechanisms to pool the risk of these increasing medical costs. The medical insurance industry was born. With this beginning, it was logical that in an age of increasing job benefits, and with government encouragement through tax incentives, that those gainfully employed should pass the cost of their insurance on to their employers. But one problem remained—some individuals and groups perceived that they could not afford the cost of these advances or at least resented the circumstances in which they were available to them. If medical care

was a "right" (and we have, as a nation, increasingly declared that it is), then surely its availability should not compete with other desires—it must be free.

The government and industry have, therefore, largely taken over the payment for medical care albeit through "third-party" payers. The great mass of individuals no longer associates medical care with personal expense. Even physicians generally look upon their fees and other costs generated in their care of patients as costs paid by insurance or government, and rarely as a burden to be borne out of pocket by the recipient of care.

And so we arrive at the present—a large and sophisticated medical establishment able to diagnose and treat with reasonable success many of the physical maladies of the human race. These results generally are perceived as good and highly desirable, and finally they are perceived as "free" by a large segment of the population.

Is there any limit to the amount of "free" medical care that a given population can absorb? ■

ANNOUNCEMENT
TO ALL

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Editorials

WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

No stampede

EVER SINCE UNIFIED membership became an annual issue at the House of Delegates sessions, nonmembers have implied that they would join the State Medical Society if they didn't have to belong to the AMA as well. The unified membership rule was dropped last spring, so now might be an interesting time to check the membership roster and see how we've done.

Between January 1 and June 20, 1980, we acquired 132 new members. Between January 1 and June 20, 1981, 144 physicians have joined—a net gain of 12.

Perhaps it's still too early to tell, but the gain so far is really negligible. It may well prove to be that the obstacle blocking the gate is not a matter of principle but rather of money—as most of us cynics have maintained all along.—WJB

No bull

A RECENT NEWS RELEASE from the American College of Emergency Physicians describes the "Urban Cowboy Syndrome." A new American fad, mechanical bull riding, has resulted in numerous injuries.

Emergency physicians in Phoenix, Arizona reported on 20 patients who came in following rides on the life-like machines. Most of the injuries occurred to those who fell from the machine, and the largest group sustained trauma from contact with the floor despite mattresses and foam. The second group of injured riders was hurt after tangling with the bull while falling, and still others received their injuries from the handle grip. Several of the patients hit the bull as they flew off, and four were injured without being thrown.

The physicians explained that there is considerable vertical force generated when the rider is tossed up, the bull goes back down, and the rider's descending spine meets the rising bull.

Apparently amateurism is also a factor since 19 of the 20 patients reviewed had no previous bull-riding experience. All had consumed enough alcohol to make its detection obvious. All injured patients had orthopedic problems ranging from sprains to fractures.

The emergency physicians warned that the machines are capable of bucking in three directions while generating the force of a live bull and that they should not be taken lightly, especially by people with a history of back or orthopedic problems—and that's no bull!—VSF

Agency atrophy

THE BULLETINS put out by the Northeastern Wisconsin Health Systems Agency are still published regularly, the latest being delivered in July 1981. The publication tries manfully to be optimistic and outlines its programs for the future of healthcare delivery in this part of the world.

There is an underlying sadness, however, when you read in the June issue about "the impact of the loss of federal funding and mandates for health systems agencies . . ." One of the articles indicated that federal funding would be available to NEWHSA through July 31, 1982 but noted that the program would be vastly curtailed, and perhaps a phase out should be undertaken rather than future planning.

Once an agency's funding is terminated, it is only a matter of time until the well runs dry. That makes the activities of the HSA a lame duck type of interim organization with limited usefulness because it has a limited future.

Would it not be better to have a quick *coup de grace* for these federal programs that are being phased out?

The bulletin also has a calendar of future events with times and dates, all of which have a somewhat melancholy flavor in view of their ultimate fate. It is rather like the death watch for a patient with a terminal illness.

Perhaps the same fate awaits PSROs (Professional Standards Review Organizations). One might hope that it will be an epidemic that spreads to other ineffective federal programs. When all of the ad hoc committees are gone, we will still have ample regulatory bodies and governmental organizations, both state and federal, to oversee medicine. Then if rules are to be laid down, it will be through the usual legislative, democratic, and constitutional methods that have worked so well in the past in this republic.

Glory, glory, hallelujah.—RAM

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Motorcycle safety month

READING THE MONDAY newspaper is about as cheerless as the late lamented body counts in Southeast Asia or Madame Defarge clicking off her victims' trips in the tumbrel to the guillotine. Here are some excerpts from recent Monday newspapers. "The helmetless victim (age 27 and not found until many hours after the accident) was thrown from the cycle and into a wooded ditch." "A Wisconsin man was killed in a motorcycle accident, an Illinois man who died in another cycle accident was identified over the weekend." "Two motorcycles collide in a dense fog and a sheriff's squad car then slammed into the wreckage, killing a woman."

The month of July was proclaimed as "Motorcycle Safety Awareness Month." The State of Wisconsin has tried to emphasize that motorcycles are legitimate motor vehicles and are entitled to full use of roads and streets. The State Highway Safety Coordinator points out that cycles are narrow and don't take up the full lane and some inconsiderate motorists tend to crowd into the same lane with them. Motorcycle registration increased 223% between 1970 and 1980 and fatalities increased 152% and injury accidents rose 180% during that same period. However, 53% of all motorcycling deaths last year were in single cycle crashes. Further, state statistics indicate that only 41% of all motorcycle riders involved in reportable accidents were wearing helmets. Seventy-three percent of those killed in single cycle accidents had blood alcohol levels more than twice the legal intoxication levels.

In the past year there have been two editorials in the *Wisconsin Medical Journal* relative to motorcycle accidents, particularly those involving helmetless drivers. These were picked up by an Associated Press writer and widely circulated throughout the state. His article drew a response from a prominent Wisconsin attorney who wrote that he had a huge volume of personal injury (both defense and offense) files involving motorcycle accidents. He added that he had an early prejudice against drivers of motorcycles, but it had been tempered by years of observing that some of the victims were indeed excellent people who operated motorcycles in a perfectly safe manner. For some reason that he could not explain he has observed a definite phenomenon, from studying these cases, that ordinary safe automobile drivers simply do not observe the presence or approach of motorcycles even though the motorcycles are sporting headlights. He has had people who have come to a rural intersection, stopped, looked both ways in broad daylight, and started up and run into an approaching motorcycle of which they were totally unaware. He commented further that in his opinion the public has no concept of how terribly dangerous motorcycles are when they are mixed on our highways with trucks and large vehicles. He felt that the helmet requirement was an alleviating factor, but its elimination returned the situation to something bordering on the barbaric. He concluded by sending his commendation to the editorial writers.

Off the road dirt-cycles don't necessarily fare much better. Recently two teenage brothers, both helmetless, collided head-on in a field. The 13-year-old was killed immediately and his 19-year-old brother sustained serious head injuries. In situations such as this, parental guidance and discretion are important factors.

Some motorists obviously detest motorcycle riders. They deliberately make it difficult for motorcyclists and do not recognize that they do indeed also have a right to the road. In other situations motorcyclists present a relatively low profile resulting in blind spots for motorists. In any event, motorcyclists could not only enhance their survival rate by wearing helmets but also they would improve their image.—VSF ■

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Equagesic®℠

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

QUAGESIC—Abbreviated Summary

***INDICATIONS**: Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information FDA has classified the indications as follows
"Possibly" effective for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache
Final classification of the less-than-effective indications requires further investigation
The effectiveness of Equagesic in long-term use, i e more than four months, has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate
WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g , alcoholics, former addicts and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination
USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.
Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under
PRECAUTIONS: Should drowsiness, ataxia or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery
Suicidal attempts with meprobamate have resulted in coma shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants e g caffeine Metrazol or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels
ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae ecchymoses, peripheral edema and fever have also been reported
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura agranulocytosis and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug
Impairment of accommodation and visual acuity has been reported rarely
OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs usually requires whole-blood transfusions
DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, PA 19101

for mild to moderate pain

Wygesic®℠

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g., driving a car or operating machinery. Patients should be cautioned accordingly.
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity (jaundice, coagulation defects, hypoglycemia, encephalopathy, coma) and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists naloxone, nalorphine, and levallorphan are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I.V., simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g., caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supp tive measures should be used as indicated. Gas lavage may be helpful. Activated charcoal can sorb a significant amount of ingested propoxyphe Dialysis is of little value in poisoning by propo phene alone. Acetaminophen is rapidly absorb and efforts to remove the drug from the body sho not be delayed. Copious gastric lavage and or ind tion of emesis may be indicated. Activated charc is probably ineffective unless administered alm immediately after acetaminophen ingestion. Neit forced diuresis nor hemodialysis appears to be tective in removing acetaminophen. Since aceta nophen in overdose may have an antidiuretic ef and may produce renal damage, administration fluids should be carefully monitored to avoid o load. It has been reported that mercaptamine (teamine) or other thiol compounds may protect aga liver damage if given soon after overdosage (hours). N-acetylcysteine is under investigation less toxic alternative to mercaptamine, which cause anorexia, nausea, vomiting, and drowsin Appropriate literature should be consulted for fur information (JAMA 237:2406-2407, 1977).
Clinical and laboratory evidence of hepatotoxicity be delayed up to one week. Acetaminophen pla levels and half-life may be useful in assessing likelihood of hepatotoxicity. Serial hepatic enz determinations are also recommended.

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for Knotts in the night

Prescribe new formula

Quinamm*

(quinine sulfate tablets)

each tablet contains quinine sulfate 260 mg

Specific therapy for painful night leg cramps

Merrell Dow

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Cayey, Puerto Rico 00633

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes, or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

Quinamm™
(quinine sulfate tablets)
AUTION Federal law prohibits dispensing without prescription
RIEF SUMMARY

DICATIONS AND USAGE
r the prevention and treatment of nocturnal recumbency leg muscle cramps

NTRAINDICATIONS
inamm may cause fetal harm when administered to a pregnant woman ngenital malformations in the human have been reported with the use of inine, primarily with large doses (up to 30 g.) for attempted abortion In about ff of these reports the malformation was deafness related to auditory nerve poplasia Among the other abnormalities reported were limb anomalies, visral defects, and visual changes In animal tests, teratogenic effects were found rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys inamm is contraindicated in women who are or may become pregnant If this ug is used during pregnancy, or if the patient becomes pregnant while taking s drug, the patient should be apprised of the potential hazard to the fetus

cause of the quinine content, Quinamm is contraindicated in patients with own quinine hypersensitivity and in patients with glucose-6-phosphate dehyogenase (G-6-PD) deficiency

ce thrombocytopenic purpura may follow the administration of quinine in thly sensitive patients, a history of this occurrence associated with previous inine ingestion contraindicates its further use Recovery usually occurs tolving withdrawal of the medication and appropriate therapy

is drug should not be used in patients with tinnitus or optic neuritis or in tients with a history of blackwater fever

RNINGS
peated doses or overdosage of quinine in some individuals may precipitate a ster of symptoms referred to as cinchonism Such symptoms, in the mildest m, include ringing in the ears, headache, nausea, and slightly disturbed ion however, when medication is continued or after large single doses, mptoms also involve the gastrointestinal tract, the nervous and cardiovascular stems, and the skin

molysis (with the potential for hemolytic anemia) has been associated with a 6-PD deficiency in patients taking quinine Quinamm should be stopped mediately if evidence of hemolysis appears

Symptoms occur, drug should be discontinued and supportive measures tituted In case of overdosage, see OVERDOSAGE section of prescribing ormation

ECAUTIONS
neral
namm should be discontinued if there is any evidence of hypersensitivity e CONTRAINDICATIONS) Cutaneous flushing, pruritus, skin rashes, fever, stric distress, dyspnea, ringing in the ears, and visual impairment are the ial expressions of hypersensitivity, particularly if only small doses of quinine have been taken Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine (See Drug Interactions)

Drug Interactions
Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration Because of possible similar effects from use of quinine it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants

The effects of neuromuscular blocking agents (particularly pancuronium succinylcholine, and tubocurarine) may be potentiated with quinine, and result in respiratory difficulties

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity

Drug Laboratory Interactions
Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used

Carcinogenesis, Mutagenesis, Impairment of Fertility
A study of quinine sulfate administered in drinking water (0 1%) to rats for periods up to 20 months showed no evidence of neoplastic changes

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test Intraperitoneal injections (0 5 mM kg) were given twice, 24 hours apart Direct *Salmonella typhimurium* tests were negative, when mammalian liver hemogenate was added positive results were found

No information relating to the effect of quinine upon fertility in animal or in man has been found

Pregnancy
Category X See CONTRAINDICATIONS

Nonteratogenic Effects
Because quinine crosses the placenta in humans, the potential for fetal effects is present Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown Quinine in toxic amounts has been associated with abortion Whether this action is always due to direct effect on the uterus is questionable

Nursing Mothers
Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts)

ADVERSE REACTIONS
The following adverse reactions have been reported with Quinamm in therapeutic or excessive dosage (Individual or multiple symptoms may represent cinchonism or hypersensitivity)

Hematologic acute hemolysis thrombocytopenic purpura agranulocytosis hypoprothrombinemia

CNS visual disturbances, including blurred vision with scotomata photophobia diplopia diminished visual fields, and disturbed color vision tinnitus deafness, and vertigo headache nausea vomiting fever, apprehension restlessness, confusion, and syncope

Dermatologic-allergic cutaneous rashes (urticarial the most frequent type of allergic reaction papular, or scarlatinal), pruritus flushing of the skin, sweating occasional edema of the face

Respiratory asthmatic symptoms

Cardiovascular anginal symptoms

Gastrointestinal nausea and vomiting (may be CNS-related), epigastric pain

DRUG ABUSE AND DEPENDENCE
Tolerance abuse or dependence with Quinamm has not been reported

OVERDOSAGE
See prescribing information for a discussion on symptoms and treatment of overdose

DOSAGE AND ADMINISTRATION
1 tablet upon retiring If needed, 2 tablets may be taken nightly—1 following the evening meal and 1 upon retiring

After several consecutive nights in which recumbency leg cramps do not occur, Quinamm may be discontinued in order to determine whether continued therapy is needed

Product Information as of October, 1980

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Direct Medical Inquiries to

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MERRELL DOW PHARMACEUTICALS INC.
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Although weight loss achieved in a weight control program varies from patient to patier this simulated sequence of a professional m illustrates dramatically the benefits of a successful weight loss program.
40
35
30
25
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getting there...

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

prescribe

Tenuate* Dospan* ⓒⅣ

(diethylpropion hydrochloride USP)

75 mg controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Precautions and Adverse Reactions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate–it makes sense. And it's responsible medicine.

Merrell Dow

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References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga M T et al: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed, New York. Raven Press, 1978, pp. 391-404.

Tenuate® ⓒⅣ
(diethylpropion hydrochloride USP)

Tenuate Dospan® ⓒⅣ
(diethylpropion hydrochloride USP) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personalty changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

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What physicians should know about children with learning disabilities

Paul A Sommers, PhD, La Crosse, Wisconsin

LEARNING DISABILITY, or LD as it is known in many medical practices, has become an all too common label that is routinely attached to any child whose learning behavior does not quite conform to what's expected of him. Recently enacted Public Law 94-142[1] (instituted in 1975) has done much to increase public awareness about "exceptional children" (children who receive special services in school to maximize their education).* However, for some children it may mean the beginning of the end of a life of "normal" development. The labelling of a child as anything but normal sets in motion thinking that discriminates inferiority. Labelling tends to influence the parents', school's, and community's expectations of the child. After being labelled as learning disabled, the child begins to be treated as a non-learner rather than a normal learner. Over time, the child begins to live and play the expected role of a non-learner. The label may perpetuate a developmental cycle of frustration and failure due to the self-fulfilling prophecy connoted by the meaning of learning disability. Once the label has been attached to the child, it becomes very hard to change. To the parent it can represent a hopeless, irreversible situation.[2]

Perhaps a more flexible interpretation of normal learning behavior should be considered. Children can be vastly different without having a brain dysfunction, a disease, or a learning disability. A variety of contemporary experts on learning problems declare that among children there exists an immense individual variation in behavior, emotion, intellect, and learning ability.[3-6] This information should be made known among parents and those professionals called upon to evaluate and help children learn.

*Children with physical, crippling or orthopedic disability; developmental disability or mental retardation; emotional disturbance; hearing disability; visual disability; learning disability; or, speech or language disability.

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Interdisciplinary issues. Professionals from the areas of medicine, psychology, and education are often called upon to help children with learning problems. Yet, it is common knowledge that there is little agreement among these professionals on the criteria used for identifying children who can benefit from specialized learning disability services. Because the types of learning problems presented are extremely mixed, the search for a common base of symptoms, pathology, or etiology has so far been fruitless.

Medical studies have been able to identify fairly reliable criteria for brain-injured children who show clearcut signs of central nervous system pathology. However, much confusion, discussion, and disagreement have developed over the observation and interpretation of "soft signs." Soft neurological signs have as their usual reference fine or gross motor deficits of obscure importance; *ie,* inability to use a scissors, poor handwriting, jerky eye tracking movements, and the like. Soft signs are not helpful findings. Most of them disappear with age. The point at which they become abnormal is not well standardized. They are so common under age seven that they should never be considered abnormal before that age. By and large, soft signs lead to additional confusion rather than clarification. Even after age seven the importance of these signs is questionable.[4]

The use of stimulant therapies to increase learning progress has been advocated by some physicians with support from educators and psychologists. However, there is no evidence that medicine increases learning. It may decrease distractibility and it may help to lengthen attention span, but it does not increase learning.[7]

Psychological findings form a major base in the identification of learning problems. Public Law 94-142 requires that professionals with training and expertise in learning assessment be engaged to test children with suspected learning problems. Such information can be used to describe the child's current learning behavior. Recommendations are given for purposes of maximizing the child's education. The interpretation of psychological information must be carefully done to avoid over simplification

or undue complexity of the problem. Some common problems of psychological interpretation include:

(A) That on the Wechsler Intelligence Scale for Children a 20 point discrepancy between scores on the verbal and performance scales is diagnostic of learning disabilities and, in some cases, of central nervous system impairment. Several other findings are more likely. For instance, high-performance/low-verbal is often found in children with auditory-perceptual problems, and in children who "act out" rather than think. Fairly common interpretations of individuals with high-verbal/low-performance test score discrepancies are neurotics, especially those with obsessive, compulsive tendencies, and children with visual-motor-perceptual problems.[8]

(B) It is quite common to find overlap between scores on visual-motor-perceptual and verbal-performance estimates among children with learning problems and children meeting standard expectations. In fact, similar to those problems with the interpretation of "soft" neurological signs previously discussed, the test error associated with visual-motor-perceptual estimates due to maturational delay of the child are so common that value of the results is highly questionable before age seven. Even after seven years of age very careful interpretation of the results is essential.[4,9]

Educators have been placed into the key position of deciding which children are learning disabled and secondly, providing specialized learning experiences to eliminate and/or allow the child to compensate for their problem(s). Public Law 94-142 states that the public school district of the child's residence is responsible to "assess" and "program" for his or her exceptional educational needs. A school program coordinator represents each identified child and is responsible for planning, implementing, and evaluating daily activities aimed at the elimination of learning problems. The school coordinator is also responsible for the coordination of related services; *ie,* medical, psychology, social work, speech therapy, counselling, remedial reading, and other necessary services. The coordinator must recognize and utilize experts from outside of the school boundaries as they are needed; *ie,* medical, psychiatry and psychology, seem to be those most frequently used.

Team approach. Individualized Education Programs (IEPs)[1] are developed for each child assessed to have a learning disability. This program places in writing all aspects of evaluation and intervention that are needed to meet the child's special needs. The IEP must be developed by the public school district. Although the public school has the main responsibility for program development, the child's physician, psychologist, social worker, or other involved person should be contacted to make sure the best possible program is developed. Parents are vital to this process and must approve the IEP in writing. Additionally, parents can change their mind if the IEP isn't working out. Parents should attend all formal meetings held by professional staff on behalf of their child.

Recommendations. *Avoid using the LD label:* If one must use labels, it is better to use those that describe the learning behavior in question or under evaluation than labelling the child as "learning disabled"; *ie,* short attention span, heightened level of distractibility, math difficulties, reading difficulties are more helpful descriptors of learning problems. The LD label is a wastebasket term without specific definition for the child it's applied to.

Be aware of false hope merchants: Inappropriate programs for children with learning problems have been erupting on a nationwide basis ever since the area of learning disabilities began receiving wide-

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spread publicity. Be wary of false hope merchants who are trying to sell expensive remediation/treatment packages. Changes in a child's learning behavior will occur as a result of concentrated training efforts over time.[9]

Keep medical evaluations reasonable: Unnecessary clinical procedures should be avoided wherever possible. A specific request must be made of the physician to answer questions about learning problems precisely as how the medical information applies to learning. It is very appropriate for parents to briefly outline their questions in writing and give them to the physician for answers. School personnel must coordinate their requests with parents and physicians in a similar manner.

Drugs are not essential to solve learning problems: Drugs or other medicines commonly prescribed for children with learning problems (*ie,* methylphenidate [Ritalin®], dextroamphetamine [Dexedrine®] etc) will not solve the learning problem. The medicine may enable the child to be more attentive in class but it is not a replacement to a structured learning program aimed at accomplishing specified educational objectives.

Keep psychological evaluations reasonable: Since psychological information (*ie,* learning and behavioral findings) is extremely important for diagnosis and the development of an individual education program (IEP), it is essential to specify in writing learning questions of concern that can be answered by this evaluation. This procedure will help the psychologist focus on suspected problem areas.

Family background is important: Knowledge of a child's world outside of school may help to explain what appears to be abnormal learning behavior. Physicians should involve both the child's parents and teachers in staffings. This opportunity will stimulate an essential exchange of case-oriented evaluation and intervention information.

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Diagnostic ultrasound increases sister chromatid exchange; preliminary report

Carol A Ehlinger, BS; K Paul Katayama, MD, PhD; Mark R Roesler, MS; and **Richard F Mattingly, MD**
Milwaukee, Wisconsin

ABSTRACT. *An increased frequency of sister chromatid exchange was seen in human cells exposed* in vivo *to diagnostic ultrasound, 5 MHZ for 30 minutes ($p < 0.005$).*

THE DETECTION OF subtle changes in DNA replication has been facilitated by the development of a sensitive 5 ′-bromo-deoxyuridine (BrdU) technique.[1] Exchanges between homologous chromatids can be seen after two cell cycles when BrdU is added to culture medium. Arresting the cells in metaphase and staining with a special stain affords differential staining between sister chromatids. This method, like the Ames Test,[2] quickly and accurately detects a sister chromatid exchange (SCE), chromosome breakage and repair, thereby lending itself to screening for potential mutagens-carcinogens.

Today, ultrasound (US) is used extensively as a diagnostic tool in prenatal diagnosis, fetal monitoring during labor, detection of neoplasms, and so forth. The diagnostic levels of US exposure have been regarded as innocuous to the developing fetus. The human chromosomes exposed to the diagnostic ultrasound *in vitro* in our previous study did not disclose increased incidence of chromosome breaks.[3]

Recently there have been conflicting reports[4,5] regarding the effect of US on SCEs in peripheral blood exposed *in vitro*. Therefore, the present study was undertaken to examine the effects of US on SCEs in a simulated *in vivo* experiment.

METHODS. In an attempt to simulate *in vivo* conditions, the following experiment was devised. Through the umbilical artery of a freshly delivered placenta, fetal blood was heparinized. Two separate and remote segments of vessels on the fetal side of the placenta were ligated. A segment of the vessel was exposed to ultrasound at frequencies of 5 MHZ for 30 minutes with a linear array sonograph (SAL-20A, Toshiba). The transducer was positioned on the maternal side of the placenta, approximately 2 cm from the exposed fetal blood. Samples of control blood and US exposed blood were then obtained from the segments, coded and thereafter treated identically.

TABLE 1—*Sister chromatid exchange (SCE) induced by ultrasound (US) exposure*

Treatment	Number of cells	Number of SCE/ Number of chromosomes	SCE per chromosomes (mean ± SD)	
US exposed	20*	150/834	.180 ± .051	$p < 0.005$
Control	20*	111/910	.122 ± .065	

*All cells came from a single human placenta.

Ten mcg/ml of BrdU was added to each specimen 24 hours after the initiation of culture with phytohemagglutinin. The cells were cultured in minimum essential medium containing 15% bovine calf serum L-glutamine and antibiotics, and incubated at 37 C with 100% relative humidity and 5% carbon dioxide (CO_2). The flasks were kept in darkness to prevent photolysis. Colcemid, 0.01 mcg/ml of medium, was added after 72 hours of growth to arrest the cells in metaphase. Cells were resuspended in 0.075 M KCl for 8 minutes and fixed in a chilled 3:1 mixture of methanol and acetic acid. Air dried slides were prepared and aged for 24 hours. The slides were differentially stained for 20 minutes with Hoechst 33258 dye, 50 mcg/ml in phosphate buffer at pH 6.4. Slides were mounted in buffer and exposed to strong sunlight for 45-60 minutes. Coverslips were removed and slides were placed in 65 C solution with sodium citrate and sodium chloride for 15 minutes. After a water rinse, the slides were stained in 5% Giesma for 5 minutes. Metaphase spreads were serially photographed with a Zeiss microscope. SCEs

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FIGURE 1A—*Examples of sister chromatid exchange (arrow) in ultrasound-exposed blood sample.*

FIGURE 1B—*Examples of sister chromatid exchange (arrow) in control blood sample.*

were scored "blindly" and only after the scoring was completed was the code broken. Statistical analysis was performed by means of Student's t-test.

RESULTS. One-hundred and fifty SCEs were observed in 834 chromosomes from 20 cells exposed to the ultrasound with mean SCE per chromosome of 0.180, whereas 111 SCEs were found in 910 chromosomes from 20 cells not exposed to the ultrasound with mean SCE per chromosome of 0.122 (Table 1). This difference is statistically significant. Therefore, the results of this analysis indicates that fresh human blood exposed to US *in vivo* shows a significant increase in the number of SCEs over the SCEs of the control sample (Fig 1A and B).

COMMENT. Investigations over the past 30 years have indicated growth retardation in plant species exposed to US.[6] Others have reported higher susceptibility to DNA fragmentation[7] and shearing[8] at various levels of US exposure.

Two recent studies [4,5] performed *in vitro* have reported conflicting results as to the effect of US on DNA. In these studies levels of US were monitored to simulate diagnostic *in vivo* levels. In each study cells were exposed to US placed in a test tube submerged in a 37 C waterbath. This technique lends itself to distortion of the sound field due to transmission through a water medium and nonbiological test tube walls. Therefore, the amount of US that reaches the cells may not be comparable to the *in vivo* situation. Our *in vivo* simulation eliminates unnecessary intervening factors.

SCE does not alter nucleotide sequence of DNA. The implications of SCE have not been fully elucidated. However, several heritable diseases such as Bloom's syndrome and xeroderma pigmentosum have been associated with elevated baseline levels of SCE. The patients with these disorders tend to develop neoplasms. Furthermore, a variety of known chemical carcinogens are known to increase the incidence of SCE.[9]

The increased incidence of SCE in US exposed cells in our study warrants a closer look at the frequent usage of US in clinical practice today.

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Antral G-cell hyperplasia (gastrinosis, gastrincytoma)

James R Starling, MD and **Vernon Hunt, MD,** Madison, Wisconsin

ABSTRACT. *A 33-year-old woman presented with severe peptic ulcer disease unresponsive to intensive medical management. Moderate fasting hypergastrinemia was found, and provocative testing revealed a supranormal gastrin response to a standard test meal. This abnormal gastrin response to a test meal is distinct from that expected in common peptic ulcer disease and Zollinger-Ellison syndrome. G-cell hyperplasia was diagnosed and the patient rendered asymptomatic with vagotomy and antrectomy.*

PATIENTS WITH peptic ulcer disease (PUD) unresponsive to intensive medical management are candidates for surgical procedures. The appropriate operation depends upon the etiology of the peptic ulcer diathesis. Until recently a patient with chronic peptic ulcers was thought to have either unresponsive PUD or the Zollinger-Ellison syndrome (ZES). Classic ZES defined as the association of peptic ulcers, acid hypersecretion, and hypergastrinemia secondary to a gastrinoma or pancreatic D-cell hyperplasia. Occasionally patients with PUD will present with a moderate increase in the fasting gastrin level. Patients with common PUD without gastric outlet obstruction usually do not have an increased gastrin. Therefore, it becomes imperative to determine whether the moderate hypergastrinemia is due to ZES by measuring stimulated gastrin levels after secretin and/or calcium infusions.[1,2,3]

Recently, antral G-cell hyperplasia has been proposed as a clinical entity apart from ZES and PUD. This entity describes patients with peptic ulcers and moderate fasting hypergastrinemia. The specific criteria for diagnosis were detailed by Ganguli, et al[4] in 1974. They described a group of non-ZES patients with peptic ulcers who had moderate hypergastrinemia and an exaggerated plasma gastrin response to a commercial meat extract. This large gastrin response to protein stimulation was in marked contrast to the modest or lack of response in normal individuals, patients with common PUD, or ZES. Straus and Yalow[5] also described four patients with hypergastrinemic hyperchlorhydria who had no evidence for gastrinoma or D-cell hyperplasia. They reported the accentuated gastrin response to a meal in these patients in contrast to patients with common PUD or ZES, and considered this a distinct nontumorous primary hypergastrinemia.

Although mentioned as part of the differential diagnosis of hypergastrinemia, most large series on ZES or PUD fail to report finding a case which met Ganguli's criteria.[6] A case of this possible, rare, clinical entity was recently diagnosed at the University of Wisconsin Clinical Science Center.

CASE REPORT. A 33-year-old female was referred to Surgery with the chief complaint of upper abdominal pain that occasionally radiated to her back. The pain was especially severe between meals and at night. Evaluation during the six months before surgical consultation consisted of three upper gastrointestinal x-ray series which demonstrated a 1.5 x 2 cm duodenal ulcer without gastric outlet obstruction. Endoscopy confirmed a deep irregular ulcer. Intensive management with antacids and H_2-blockers failed to alleviate her symptoms and heal the ulcer.

A fasting gastrin was obtained to exclude the remote possibility of ZES. Her basal gastrin after a 12-hour fast and 24 hours off of all medications was 320 pg/ml (Bio-Science Laboratories, Van Nuys, CA. Normal $<$ 100 pg/ml). A repeat determination was 258 pg/ml. The rest of her chemical values as well as screening for other endocrinopathies were normal. Gastric secretory studies showed normosecretor values: BAO of 4 $mEqH^+/h$, MAO of 16 $mEqH^+/h$, and a BAO/MAO = 0.2.

Because of the remote chance that her moderately elevated hypergastrinemia reflected ZES, she underwent provocative testing. This consisted of a standard test meal-STM-(2 eggs, 2 pieces of toast, 2 pats of butter, juice), and intravenous bolus secretin (2 U/kg).[2,3,4,6] Her response to the STM was greatly exaggerated ($>$500% of basal gastrin) with an integrated gastrin response (IGR) of 533. Her gastrin levels fell after intravenous secretin (Fig 1).

The patient had an uncomplicated antrectomy and vagotomy after a thorough intraabdominal exploration. A large posterior duodenal ulcer was

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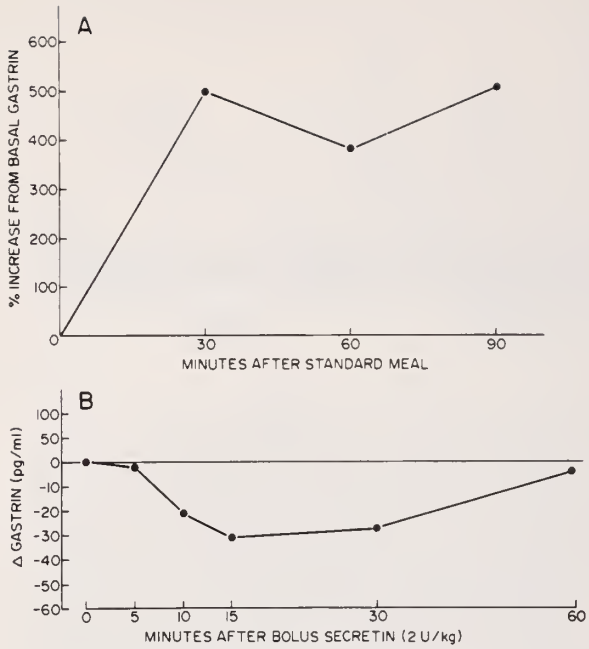

FIGURE 1—*Testing for Zollinger-Ellison syndrome*

found. Immunoperoxidase staining of the midantrum had 34.7 G-cells per field compared to antral tissue from a patient without ulcer disease of 30.6 G-cells per field (400x).

Two months postoperative the patient's gastrin level was < 75 pg/ml. She is free of gastrointestinal complaints one year after surgery.

DISCUSSION. The patient presented above meets the criteria established by Ganguli and others[4,5,7] to diagnose antral G-cell hyperplasia or antral gastrinosis. In contrast to patients with hypergastrinemia secondary to a gastrinoma or pancreatic D-cell hyperplasia, she had a supranormal response (> 500% over basal) to a standard test meal. This supranormal gastrin response is in sharp contrast to the lack of response in the hypergastrinemic patient with autonomously functioning tissue (ZES). It is known that normal individuals and those with common PUD can have an elevation in fasting gastrin with protein stimulation. The magnitude of the response to diagnosis G-cell hyperplasia is critical; most reports state that patients with G-cell hyperplasia have > 350% increase in gastrin after a STM compared to 120% to 150% for normals and common duodenal ulcer patients.[4,5,6,7] Patients with gastrinoma have only a 10% increase with STM.[6] In addition, the decrease in gastrin to intravenous secretin supports G-cell hyperplasia in contrast to ZES, according to one report.[7]

That abnormal gastrin release could be present from a source other than a gastrinoma or pancreatic D-cells was initially proposed by Solcia, et al.[8] Following this, Polak, Stagg, and Pearse[9] described four patients with assumed ZES in which no tumor or pancreatic hyperplasia was found, and profound G-cell hyperplasia by immunofluorescent analysis of antral G-cells was seen (Type I-ZES). Patients with gastrinoma (Type II-ZES) had normal antral G-cells[9,10] Ganguli and coworkers[4] were also able to demonstrate G-cell hyperplasia in patients with hypergastrinemia without ZES. The patients reported by other investigators[5,7] did not mention the quantitative G-cell mass. Whether quantitative antral G-cell numbers are specific enough to confirm this as a distinct clinical entity, however, is still debatable.[11]

Friesen described antral G-cell hyperplasia (gastrincytoma) as part of the multiple endocrine neoplasia syndrome because of the occasional association with acromegaly, hyperparathyroidism and medullary carcinoma of the thyroid.[12] Although hypothetical, he believes that antral G-cell hyperplasia may precede or be an intermediate step in the development of pancreatic tumors and possibly may predict the development of other endocrinopathy.[13]

Another possible explanation of the role of G-cell hyperplasia was postulated by Byrnes, Lam, and Sircus[14] who grouped PUD patients with "normosecretors" (similar to our patient) and "hypersecretors." They claim that patients with PUD initially undergo antral G-cell hyperplasia with normosecretion and greater gastrin release after a STM. Partial cell hyperplasia follows which results in acid hypersecretion and gastrin inhibition.

Whether G-cell hyperplasia (gastrinosis, gastrincytoma) is a definite clinical entity is still not certain. However, clinicians will occasionally see the rare patient with moderate hypergastrinemia and peptic ulcers with or without acid hypersecretion. If this is due to gastrinoma or pancreatic islet hyperplasia, end-organ excision (total gastrectomy) is advocated. Only limited success has been reported in the use of H_2-blockers to treat ZES. If G-cell hyperplasia can be diagnosed, a less formidable and rational operation should be done. The first report of successful surgical management of G-cell hyperplasia was hemigastrectomy.[4] Hansky's three patients were reportedly cured by antrectomy alone.[7] In his small number of patients without other endocrinopathy, Friesen has recommended antrectomy and vagotomy.[13]

Because of the inability to accurately quantitate antral G-cell number and/or antral gastrin content preoperatively, it is impossible to precisely know whether antral G-cell hyperplasia in the strictest of definitions is present. For that reason the diagnosis is established by the clinical association of moderate fasting hypergastrinemia, peptic ulcers, and an exaggerated response to a standard test meal. The rare patient who fits these criteria can be cured by antrectomy and vagotomy.

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MEDICAL BRIEF

TRH testing and depression

OVER THE PAST several years numerous articles have been written suggesting that the diagnosis of unipolar depression be guided by the TRH (thyrotropin-releasing hormone) stimulation test. These studies suggest that the response of thyroid-stimulating hormone (TSH) to TRH is diminished in subjects with unipolar depression as compared to nondepressed controls. This is in contrast to the reported preservation of TSH suppressibility by 3,5,3′-triiodothyronine (T_3) administration in depressed subjects. It is imperative, however, that the clinician remember that a blunted TSH response to TRH is inconclusive in terms of the thyroid-pituitary axis; due to test and population variation, the TSH response to TRH must be flat before the diagnosis of an autonomously functioning thyroid gland can be made. After reanalyzing several studies[1,2,3] and eliminating the clearly abnormal TRH tests showing either a flat or hyper-response, we conclude that there is no longer a statistical difference in TSH response between depressed and control subjects. Upon further review of this literature, one can not help but notice the large number of "flat" responses to TRH in depressed yet apparently euthyroid subjects. Should one conclude from this that depression is more common in euthyroid subjects with autonomously functioning thyroid glands (*ie,* Graves' disease or autonomous thyroid nodules)? Little mention is made of the examination of the thyroid gland in many studies reporting abnormal TRH responses associated with depression. Additional work clearly needs to be done to further define this relationship.

In addition, it is important to remember that there are numerous potential causes of a blunted TRH response. Besides an autonomously functioning thyroid gland, glucocorticoid excess and phenytoin (Dilantin®) usage are common causes for a blunted TRH test. Data also suggest that progressive age, especially in men, results in a blunted TSH response to TRH.[4,5] The diagnostic acumen of depression may be improved by tests assessing the endocrine axis; however, one must exercise extreme caution and not over interpret laboratory findings.

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Is radionuclide brain scanning an adequate evaluation for cerebral metastases in asymptomatic lung cancer patients?

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WHILE THE radionuclide (RN) brain scan is inferior to computerized tomographic (CT) scans in the detection of cerebral tumors,[1,2] it remains the principal imaging procedure available to clinicians in small or community hospitals. RN scanning will remain the major diagnostic tool because of regulations limiting the widespread use of CT scanners. Because of the report of the useful role of CT imaging in the detection of cerebral metastases in neurologically intact lung cancer patients[3] and the statement that RN imaging is not indicated in these patients, a retrospective study was undertaken to investigate the role of RN imaging in this situation.[4] The literature was reviewed with the object of determining whether patients in smaller hospitals were having their investigation and management compromised by the absence of CT scanners.

METHODS. During a three-month period in 1977, 486 patients were referred to the Department of Physics/Nuclear Medicine for RN bone imaging.[4] The bone scan was reviewed together with the information supplied with the consultation request which included symptoms, physical signs, provisional diagnosis, final diagnosis, and method of establishing this definitive state, *eg* surgery. In addition, any RN brain scans obtained on these same patients were reviewed and the clinical findings as given on the request form were tabulated. In particular, the presence of focal or diffuse neurological signs or symptoms was sought.

The data, including that abstracted from the literature, were analyzed using chi-square analysis of contingency tables. The null hypothesis assumed no difference in compared populations, and the level of significance was selected at 0.05.

RESULTS. In the retrospective three-month survey, there were 318 established tumor patients, of which 162 (51%) had RN brain scans performed as part of their diagnostic workup. Seventy-three patients had lung cancer, and the remaining 89 had miscellaneous other tumors.[4] There were 149 normal and 13 abnormal brain scans. The referral form contained information concerning the presence of neurological signs in all 13 abnormal scan patients, and focal neurological signs were present in each case (Table 1). In five instances there were bilateral neurological signs, and in each patient two or more focal scan abnormalities were identified. Of the 149 patients with no scan abnormality, 136 had no, or no mention of, neurological signs while 13 had either diffuse or focal neurological signs present (Table 1). Three patients with focal neurological signs had documented past cerebrovascular accidents.

In a review of the available literature of patients with lung carcinoma,[5-12] an incidence of 12 abnormal scans in 379 total studies was found in neurologically intact patients, and the lesion rate within these populations was similar ($p = 0.41$). When the 73 lung cancer patients of this series were included (Table 2), the resulting frequency distribution was still statistically similar. This was compared to the largest published series of neurologically intact patients with lung cancer on whom CT scans were performed,[3] and no statistical difference was detected in the ability of the two techniques to detect intracranial metastases (chi-square = 1.34, df = 1, $p = 0.25$).

When the available literature of RN brain scanning neurologically intact nonpulmonary tumor patients was reviewed,[12-14] and our series of 89 patients was added (Table 3), the detection rate was only one abnormal scan in 398 total patient scans, and that was unconfirmed histologically. This lesion rate was significantly different from the 12 abnormal RN scans found in 452 lung cancer patients (chi-square = 8.14, df = 1, $p = 0.004$).

DISCUSSION. In cancer patients in general, the distribution of metastases appears related to the mass of the tissue metastasized and its blood supply.[15,16] In a large autopsy series of patients of all tumor types there was a 24% incidence of intracranial metastases. Of these, 9% were limited to the brain substance leaving a 15% incidence with dural or leptomeningeal involvement.[15] Three-quarters of all

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TABLE 1: *Presence of neurological signs compared to presence of radionuclide (RN) brain scan abnormality*

	SCAN RESULT	
Neurologic signs	*Normal*	*Focal abnormality*
None	136	0
Focal	7	13
Diffuse	6	0

Chi-square = 100.4, dif = 2, $p < 0.0001$

TABLE 2: *Published abnormal radionuclide (RN) brain scanning detection rates for cerebral metastases in neurologically intact pulmonary carcinoma patients*

Author	*Total patients*	*Positive scan*	*Year published*
McCormack[5]	43	1	1968
Hayes[6]	37	2	1971
Taylor[7]	39	0	1976
Operchal[8]	56	4	1976
White[9]	84	4	1976
Delaney[10]	15	0	1976
Wittes[11]	35	0	1977
Vieras[12]	70	1	1977
This series	73	0	1977
TOTAL	452	12	

Chi-square = 11.73, df = 8, p = 0.16

TABLE 3: *Published abnormal radionuclide (RN) brain scanning detection rates for cerebral metastases in neurologically intact patients with tumors other than pulmonary.*

Author	*Total patients*	*Positive scan*	*Year published*
Felix et al[13]	164	0	1975
Muss et al[14]	79	?1	1976
Vieras et al[12]	66	0	1977
This series	89	0	1977
TOTAL	398	1	

metastatic patients will have suffered some neurological symptom during life, and indeed many would have been seriously disabled or died as a direct result of the metastasis. Careful neurological examination of these patients demonstrates physical signs unnoticed by the patient; *eg,* 40% complain of motor weakness, but in 66% a detectable hemiparesis is present; and while 31% of patients or their families complain of behavioral or mental changes, 77% have impaired cognitive function.[16] This literature emphasizes the very high incidence of neurological signs when patients are carefully examined, and it may be inferred that most patients with intracerebral metastases would have neurological signs present if examined by a neurologist.

The patients most commonly presenting with cerebral metastases are those with pulmonary carcinoma, although other tumors (*eg,* malignant melanoma) may have a higher relative incidence of cerebral metastases.[15] In general, tumor patients with cerebral metastases often have pulmonary metastases, a fact thought to be explained by the need of the tumor cells to traverse the pulmonary circulation before seeding into the brain parenchyma. However, there is a clinical impression that lung carcinoma patients often present with cerebral metastases without evidence of other organ involvement, and this in part explains the diligent search made for central nervous system (CNS) lesions in patients being considered for curative surgery. This search is currently undertaken regardless of whether neurological symptoms or signs are present or not.

The literature establishes the advantages of CT brain scanning over RN studies in the detection of intracranial tumors in general. These features include an improved sensitivity in lesion detection as well as the detection of associated anatomical deformities away from the lesion; *eg* ventricular distortion.[1] In metastatic disease this is also the case, and the reported false negative rates are 15% for RN studies compared to 6% for CT studies when supratentorial metastases (80% of total) were considered. This difference in detection rates is highly significant (chi-square = 12.24, df = 1, $p = 0.0005$). However, in a separate report of the same study using a subset of patients in whom histological proof of intracranial metastatic disease was available there was no statistically significant difference in sensitivity when RN scanning was compared to CT without contrast, and the confidence level was barely significant ($0.05 < p < 0.1$) when compared to CT with contrast. The reported sensitivities were: 83% for RN, 94% for CT without contrast, and 97% for CT with contrast, but because of the numbers of these histologically proven cases, these apparently large differences in sensitivities were not established to be statistically significant in this patient series. It would be improper to suggest that because of this, RN scanning is established as equally effective in detecting patients with metastases; but it does highlight the very low incidence of cerebral metastases in neurologically intact patients with lung cancer and the need to be very careful in suggesting an imaging modality as inappropriate. This is especially so when the alternative imaging procedure is not always available to the general population.

The question of the role of various investigative techniques in these tumor patients is the subject of this review. Butler et al[3] have argued that a 5% yield of previously unrecognized metastases is worthwhile when the expense and morbidity of surgery are the sole criteria considered. Unfortunately, they imply from the literature they cite that similar results would not result from RN brain scanning. The statistical analysis of the data they cite, and for the patient populations of our series and that available in the literature, would provide no basis for that statement. This is despite the established difference in sensitivities of the two procedures in proven metastases[2]

and may be largely attributed to the very low incidence of metastases in neurologically intact patients. From the currently available data it can be stated the neurologically intact candidates for curative lung cancer surgery are not inadequately evaluated when imaged with RN techniques because of the absence of CT facilities.

However, one would caution that in a large patient series a difference in imaging modalities may be demonstrated. Furthermore, because of the relatively high incidence of dural metastases and the report that the RN scan is more sensitive in their detection because of the frequently associated skull involvement,[2] additional useful information may actually be provided by using the RN technique.

Unfortunately, there is no literature available to determine whether a careful neurological assessment by a competent neurologist, an investigation that is less expensive than any imaging modality, may in fact be the best available screening procedure. Any study designed to compare the imaging modalities should perform both techniques on the same patients, and should also include a careful physical examination.

A word of warning is given against the wholesale use of routine brain scans in neurologically intact patients with nonpulmonary tumors regardless of imaging modality. In these patients the incidence of detected RN abnormalities is significantly less than that detected in the lung cancer group, suggesting that the potential yield is minimal. This is confirmed by the literature, which does not propose the use of brain imaging in tumor patients without neurological signs.

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ABSTRACT

Serum concentrations of the iodothyronines in elderly subjects: Decreased triiodothyronine (T_3) and free T_3 index

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In four groups of subjects free of thyroid disease, the following determinations were made: serum concentrations of thyroxine (T_4), triiodothyronine (T_3), reverse T_3 (rT_3) and diiodothyronine (T_2), and calculated indices of free thyroxine (FT_4) and free triiodothyronine (FT_3). Group A comprised healthy subjects aged 16-64; Group B, 24 healthy elderly subjects aged 68-95; Group C, 23 elderly patients with mild well-controlled chronic illnesses, aged 70-85; Group D, 40 nursing home residents aged 66-100. Serum T_4 and T_2 concentrations and the FT_4 index were not affected by age; the rT_3 concentration was slightly but significantly elevated only in Group D patients. Serum T_3 concentration was significantly lower in all groups of elderly subjects and decreased FT_3 index measurements were detected after age 75. It was concluded that old age, without complicating illness, is accompanied only by a decrease in the serum level of T_3 and the FT_3 index; values for other iodothyronines are unchanged. Clinicians should consider the age-related changes in T_3 and FT_3 values when interpreting thyroid function tests.

SMS to undertake medical liability studies

The SMS Board of Directors July 18 authorized a series of studies regarding medical liability in Wisconsin. The first study involves research into the types and frequency of malpractice suits in Wisconsin since 1975 and evaluation of malpractice prevention programs in other states. The prime question is whether malpractice prevention efforts could be helpful in retaining Wisconsin's better-than-average loss experience.

In a related action the Board asked its medical liability actuary to study the liability rate setting, reserving, underwriting, and claims management of WHCLIP and the state umbrella Patients Compensation Fund. It is seeking to prevent a recurrence of the liability "crisis" of the early 1970s, evidence of which is making headlines in New York.

In other action the Board:

• Supported efforts to include in the Wisconsin Administrative Code, or failing that through legislation, a requirement that hospital employees and medical staff be immunized or demonstrate immunity to rubella. The board stipulated that any such effort should have the State assume any potential liability.

• Heard a report from SMS President-elect Gerald C Kempthorne MD, Spring Green, regarding his testimony before a US Senate Subcommittee on Federal Trade Commission activities concerning the learned professions. (See complete text of his testimony elsewhere in this issue.)

• Agreed to inform the Dept of Health and Social Services that physician contracts for providing Medicaid services will be invalid if it maintains its position of limiting physician reimbursement to 4.5% during the coming year. (Wisconsin Medicaid contracts with physicians require that the state comply with the 1981-82 economic index adjustment applied by the Federal government to Medicare which is 7.5%).

• Directed development of sample "pre-service agreement" forms in which a patient agrees to pay a fee irrespective of what an insurance company or other third-party carrier pays.

• Referred back to the Committee on Aging and Extended Care Facilities its Proposed Guidelines for Terminal Care (In Long-Term Facilities).

• Approved sponsoring an SMS Planning Conference for SMS directors and officers, commission and committee chairmen, county and specialty society presidents and auxiliary officers on November 6-7 at the Brookfield Marriott.

• Adopted the 1981 Principles of Medical Ethics of the American Medical Association as the ethical guidelines of the State Medical Society of Wisconsin. See p 67, June *WMJ* BLUE BOOK.

• Appointed the following physicians to SMS commissions and committees: Frank E Berridge MD, Milwaukee, and Joseph J Mazza MD, Marshfield, to the Commission on Continuing Medical Education; Carl R Poley MD, Green Bay, to the Commission on Public Information; Janet C Lindemann MD, Waukesha, to the Committee on Women Physicians; and Herbert C White DO, Genesee Depot, to the Committee on Alcoholism and Other Drug Abuse.

• Will appeal to Wisconsin Physicians Service on behalf of an osteopath-neurologist member that WPS discontinue its practice of establishing his profile separately from those of MD neurologists.

• Decided not to enter a suit of the Wisconsin Hospital Association dealing with a revised Medicaid reimbursement system for hospitals.

• Approved legislation developed by the SMS Ad Hoc Committee on Quality Assurance which calls for reporting the loss, reduction, or suspension of hospital privileges or the resignations from a hospital medical staff to the Medical Examining Board. The Board stipulated that the bill require that the restoration of privileges also be reported. The SMS legislation is intended to improve SB 68 on the same subject.

• Supported, with some modifications, a bill which requires parents or legal guardians to use approved automobile child restraint systems on their children under four years of age.

• Confirmed the appointment of the following section representatives to the Commission on Governmental Affairs: Neal Taylor MD, LaCrosse, Physical Medicine and Rehabilitation; Harry J Zemel MD, Fond du Lac, Pathology; and George F Flynn MD, Milwaukee, Surgery.

• Agreed to cosponsor a course on proper prescription practices with the State Controlled Substances Board.

• Announced that effective August 1, SMS Services Inc will act as the agent of record for SMS member insurance programs.

• Supported SB 310, the Omnibus Drinking-Driving Bill which would stiffen the Drunk Driving law in Wisconsin. ■

PHYSICIANS SEEING FEWER PATIENTS, SPENDING MORE TIME WITH EACH. American physicians are spending more time with their patients in the 1980s according to the AMA's *Profile of Medical Practice, 1981.* Physicians in 1980 had an average of 112 patient visits per week, which is less than the average of 122.7 patient visits in 1979 and 130.6 in 1978. The average physician's work continues to be about the same: 44.5 hours of direct patient care in 1980 as compared with 44.9 hours in 1979 and 45.4 hours in 1978. ■

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DHSS audit of Medicaid practices seeking more than 'Medicaid' information

SMS Secretary Earl Thayer has formally objected to the Dept of Health and Social Services regarding its condonence of activities by an auditing firm it has contracted with to audit the Medicaid practices of 25 selected physicians, dentists, and pharmacists.

Recently a medical clinic, which is the object of an audit by the firm, J L Trainor Co, reported that Trainor people sought to explore not only Medicaid records but also general business information such as the total number of persons employed by the clinic, their salaries, and fringes, rent, and overhead costs of various types.

SMS legal counsel advises that the auditing firm has no right to such information. While a spokesperson from the Dept of Health and Social Services agreed with the SMS legal advice and said the Department did not endorse Trainor's actions, the spokesperson said that the Department would not tell Trainor to stop.

"DHSS has a clear public obligation to conduct audits in situations where there appear to be unusual or unexplained patterns of Medicaid practice or charges, and if the facts are supportive, to order the return of funds or impose sanction," Thayer said in a letter to DHSS Secretary Donald Percy.

"However, the conduct of the Trainor Co in the current audit is, if not beyond the scope of the law, certainly unethical."

"On behalf of the members of the Society, I request that DHSS direct J L Trainor Co to cease and desist in this unwarranted and unauthorized activity. At the same time, we are filing copies of this letter as a complaint to the appropriate public regulatory agencies and voluntary professional organizations," Thayer said.

SMS legal counsel suggests that physicians confronted with representatives of the Trainor Co (JLT, Inc) refuse any requests to see records that are not directly related to the provision of Medicaid services. Should JLT representatives seek to review private patient records (non-Medicaid), it is suggested that the physician refuse pending a contact with the patient to determine whether the patient is willing to have the Department review his/her records. In such circumstances it also would be advisable to contact SMS corporate legal counsel, H B Maroney, in Madison pending further clarification of this issue with DHSS.

State Budget story nears conclusion

The State Budget Bill came back to Governor Dreyfus in late July after both legislative houses reached agreement on a budget package. The Governor and his staff then began their work of reviewing the Budget and deciding what portions should be changed via the line item veto.

Democratic caucuses in both houses reached an agreement on a $14.5 billion budget bill package July 16. By a vote of 50-44, the bill then passed on the Assembly floor and received Senate approval the following day.

During the Budget process the Medical Society monitored various provisions of the bill and sought to incorporate, amend, or delete items with varying degrees of success. Those items which remain in the overall package sent to the Governor include:

- **Hospital and Nursing Home Moratorium**—A two-year moratorium on certificate-of-need projects for hospitals and nursing homes. The moratorium, with certain exemptions, applies to all projects without completed certificate-of-need applications as of May 1, 1981. For hospitals, only those projects in excess of $1 million are included. Although the Medical Society did not support the moratorium, it did assist in rewriting the Governor's original language. Part of the Society's rewrite included the repeal of the statutes authorizing the decertification of certain specialized hospital services.

- **Community Options Program**—A Community Options Program for disabled and elderly persons beginning in calendar year 1982 with up to eight volunteer counties. The program is intended to target shrinking public resources toward persons at greatest risk of entering nursing homes. Nursing home care is nearly 60% of the Medicaid Budget and Medicaid is expected to be a $1 billion program by the second year of the biennium. Every person eligible for Medicaid, or nearing eligibility because of depleting personal resources, who is planning to enter a nursing home would be assessed to determine whether assistance at home could accomplish what is needed instead of nursing home placement. The unique needs and abilities of each individual assessed will be matched against the array of services and living arrangements available in each county. An assessment determination that nursing home care is not appropriate supercedes a physician's plan of care authorizing nursing home care if the assessment determination includes review by a physician. (The Medical Society attempted to amend this provision to include "review 'and concurrence' by a physician.") Participating counties will develop individual community options plans to be submitted to DHSS for approval. In calendar year 1983 additional counties, with at least 70% of the State's nursing home population, will be required to participate.

continued next page

• **Family Practice**—A Medical Society supported amendment to provide $598,000 to the UW Department of Family Medicine and Practice. The additional funding was necessary to prevent the closing of either the Wausau or Eau Claire family practice residencies.

• **Podiatrists**—An amendment in the Senate which reinstated podiatrists as Medicaid providers. Because podiatrists were removed from earlier versions of the Medicaid Budget, a provision was inserted to limit reimbursement to physicians, who perform surgical procedures that are within the scope of podiatric practice, to a rate determined reasonable by DHSS. Attempts by the Medical Society to remove this provision were unsuccessful.

• **Lab and X-ray**—A limit on hospital Medicaid reimbursement for outpatient lab and x-ray services to rates not to exceed reimbursement for comparable services performed by providers not owned or operated by hospitals. Efforts to remove this provision also failed.

• **Minimum Coverage for Mental and Nervous Disorders**—A Medical Society supported amendment raising the minimum coverage under private insurance plans for outpatient treatment of mental and nervous disorders, alcoholism, and drug abuse from $500 to $1000 annually.

• **Adult Corrections**—A Medical Society supported amendment which prohibits the partial conversion of the Winnebago Mental Health Institute for use as an adult correctional facility. Construction of a separate correctional facility was adopted as an alternative.

• **Operating While Intoxicated**—An amendment incorporating the provisions of SB 310 which includes extensive modifications to the statutes governing the operation of motor vehicles while intoxicated. The amendment increases current penalties and forfeitures and was supported by the Medical Society. ■

President-elect Kempthorne testifies in Washington DC

TESTIMONY before the United States Senate—Committee on Commerce, Science, and Transportation/Subcommittee on Consumer—Wednesday, July 15, 1981, by *Gerald C Kempthorne, MD,* President-elect, State Medical Society of Wisconsin

***

I AM GERALD KEMPTHORNE MD, a family practitioner from Spring Green, Wisconsin. I have served as a member of the State Medical Society of Wisconsin's Commission on Mediation and Peer Review for nine years, and as its chairman for the past eight years. In addition, I am currently president-elect of the State Medical Society. While I hope to focus the majority of my remarks in connection with my role as chairman of the Commission on Mediation and Peer Review, I will also briefly summarize some other areas in which we have concerns.

The purpose of the Commission, of which I am chairman, is to receive, investigate, and seek to resolve differences between physicians and patients or other complainants, or between physicians, on matters relating to quality of care, professional ethics, and fees. When necessary, it may initiate disciplinary or other action as appropriate. It is designed to serve as the Society's advisory body to private or governmental organizations on matters affecting medical peer review including utilization review, appropriateness of care, fees, and quality assurance.

The work of this Commission has as its main thrust questions from patients regarding the type of care they have received, the outcome of that care, and whether the scientific procedure was correct, and, in many instances, whether the fees charged for such care are reasonable. Many hours of physician and staff time are spent in developing data from the patient, from his or her providers of care, and other healthcare institutions. This information is needed if the Commission is to make an impartial and reasoned decision regarding the questions submitted.

Quality of care is not comprised of a single issue. It necessarily includes both the art and science of medicine as well as the patient's own social history and his or her environmental surroundings. It is virtually impossible to look at the quality of care and to answer the patients' questions without touching upon the types and quantities of services ordered and the cost of these services. Since the Goldfarb decision and FTC official rulings and opinions, the Commission on Peer Review has felt that it is not able to do a thorough job because of the constraints, both real and anticipated, being placed upon it. It is most difficult to proceed in many given medical peer review situations without more advice from attorneys than physicians. In many instances, the final issue is not whether the patient was served. It is whether the method of trying to determine that issue might indeed violate FTC rulings. In this setting, many times the patient's questions are not answered adequately because the Mediation and Peer Review Commission feels that it is constrained in the thoroughness with which it may investigate and indeed take action because of threatened antitrust charges. This, coupled with strong concern for the right of due process, unfortunately at times makes the patient in effect the loser. As a result of these constraints on peer review, individuals who might be guilty of providing questionable medical care escape the criticism and corrective action of their peers.

It is the Society's position, and has been since its founding in 1841, that its prime function is to raise the standards of medical care and to provide access to care for everyone. For example, pursuant to Wisconsin statutes, the Society at one time founded a Blue Shield plan in order to experiment with increasing benefits and access of patients to health insurance, as well as assuring reasonable payments to providers. Information was gathered to enable the development of this third-party protection for patients. The Society's activity in this field lasted almost 25 years. It then divested itself of this plan which had developed into a full-fledged health insurance operation. Let me emphasize again that what had been done during all those years was totally consistent with the enabling statutes of the State of Wisconsin. But a few years ago, the Society found itself subject to the inquiries of the FTC. We spent thousands of dollars on staff and legal fees and mailed boxes and boxes of documents to FTC, which was investigat-

continued next page

ing the Society's relationship with its own legally authorized prepaid plan. The main point in this area is that there obviously is a conflict of laws. The Society has never attempted to hide any of its activities and indeed was conducting them under the sanction of Wisconsin law.

Another example of difficulty is requests by the State of Wisconsin Health and Social Services Department to assist it in getting information and developing guidelines on the quality of care and benefits of the Medicaid program in the state. On the one hand, the Society is being asked to assist. On the other, it has been told that there are potential problems. Immunity is not certain, even when assisting in government requested peer review, if a physician's utilization patterns and charges may be in doubt.

A recent decision by the Federal Trade Commission has told one state medical society that it should no longer initiate or participate in healthcare cost containment talks with the state's Medicaid program. Even though the latest information seems to indicate that a Society can respond when asked for advice by third-party payors such as insurance companies or governmental agencies, it does not indeed provide for adequate physician input or allow any degree of certainty as to what individual physicians, working through their professional association, may do.

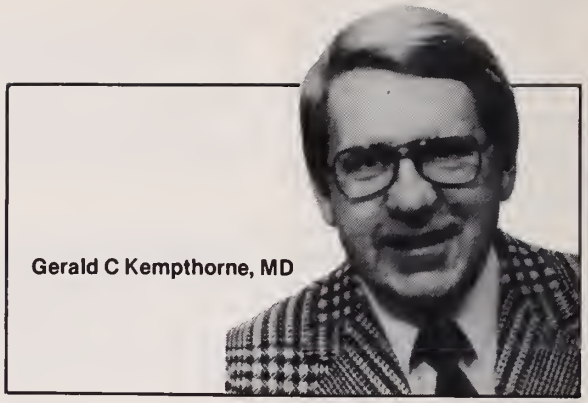
We face the same uncertainty in Wisconsin as we seek to work with our Department of Health and Social Services on federal as well as state programs. While the federal government on one hand appeals to medicine, it chills these efforts with strong threats of antitrust for even talking about fees, for even trying to control use or abuse of services.

These are a few of the problems that we are encountering because of the Federal Trade Commission's activity. As I previously stated, we have almost reached the point where we have difficulty in improving the standards and quality of medical care because we are often more concerned with federal policies than with spending our energies productively in determining the data and truth about the care being provided.

We feel there must be a way that a professional society can indeed work with its members—including disciplining its members when necessary—to maintain and upgrade quality in a cost-effective manner for the interest of better care for the patient. We are informed by our attorneys and various publications that FTC opinions and/or regulations concerning peer review raise antitrust questions when that review is dealing with fees in connection with over-utilization and standards of care. We don't seek to stifle competition, but we do seek consistency and a clear pattern of what can and cannot be done. Also we seek the right to speak to the medical aspects of medical care. We know how to get the job done, but FTC threats repeatedly block effective implementation. We ask you to help by removing the stumbling block and letting us do the job.

We find that a vast number of rulings and questions from FTC are threatening to stop one of the basic activities and functions of our professional organization: working to give advice to third-party carriers upon the request of those entities in processing health insurance claims. The need for such an exchange of information is basic to evaluating good care.

In addition, while the courts are imposing higher standards of care on hospitals in their selection process of physician and other staff members, the FTC says there are antitrust issues involved in determining qualifications, access to


Gerald C Kempthorne, MD

facilities, contracts with providers, and the disciplining of the same when it becomes necessary.

We are also asked for our input into health planning, as well as our comments as a Society on other government regulations. However, when we respond to these requests such as our role advising the State of Wisconsin's Medicaid Audit Committee, we are threatened with accusations of antitrust activity.

Our comments on the policies and benefits of insurance carriers and government programs (unless formally requested by provider) are all areas of potential difficulty with the FTC.

When we attempt to give advice—not to make mandatory rules or to threaten discipline or censure in any way—just give advice, we seem to do so with the threat of a potential antitrust violation.

The State Medical Society of Wisconsin does not have and has never had as its prime motive the interference with the patient-physician relationship. In fact, it has been a champion of free choice. It can not, nor does it intend to control or adversely influence the practice of medicine.

Regardless of the rulings, we do not and have not approached our chosen discipline on other than a professional basis. Medicine is not a factory. We believe that neither the Wisconsin nor the American public wants factory medicine which would destroy the individual relationship between the provider and the patient. The public also has a right to have that relationship subject to peer review without unnecessary time-consuming and restrictive federal regulations which serve only to hinder the flow of quality care. The medical profession in Wisconsin is licensed as it is in every other state in the United States. There are standards to be met which are appropriate and necessary. The profession of medicine requires that the care provided be subject to review by the peers in that profession without being subjected to confusing, overly complicated, and uncertain regulation which only delays quality care and makes it more expensive. ■

SENIOR PHYSICIANS GROUP TO SPONSOR MD HOBBY DISPLAYS. Do you have an interesting collection or hobby, or do you engage in a particular art or craft? The Wisconsin Association of Senior Physicians announces that it is sponsoring an exhibit area at its October 17 Annual Convention to give senior physicians who paint, sculpt, carve, have unusual collections or hobbies an opportunity to display their efforts. Interested physicians should contact Guy M Carlson MD, in care of the State Medical Society of Wisconsin, PO Box 1109, Madison, WI 53701. ■

Physician Briefs

*Physician members of State Medical Society of Wisconsin

Douglas C Gremban, MD, recently joined the medical staff on the Eagle River Memorial Hospital. Doctor Gremban graduated from the University of Minnesota Medical School and completed his family practice residency at the Midland Hospital Center, Midland, Mich.

Stephen R Schmitz, MD, Hudson, recently began his medical practice at the Hudson Clinic. Doctor Schmitz graduated from the University School of Medicine at Indianapolis, and completed his family practice residency at St Mary's Hospital in Milwaukee.

Ben R Lawton, MD,* Marshfield, recently received the 1981 Max Fox Preceptor Award of the University of Wisconsin Medical School. A surgeon at the Marshfield Clinic, Doctor Lawton graduated from the University of Wisconsin Medical School and served his general surgery residencv at the Gunderson Clinic in LaCrosse.

John C Zeldenrust, MD, Two Rivers, recently became a member of Doctors Clinic in Two Rivers. Doctor Zeldenrust graduated from the University of Michigan Medical School and completed his residency training at the University of Colorado Medical Center in Denver. Prior to becoming a member of Doctors Clinic, Doctor Zeldenrust had been associated with the Defiance Clinic in Ohio. He is certified by the American Board of Surgery.

Cameron B Gundersen, MD, LaCrosse, recently was named Pediatrician of the Year by the Wisconsin Chapter of the American Academy of Pediatrics. Doctor Gundersen was cited for his involvement in initiating Wisconsin's immunization record card system and developing legislation for the establishment of Mosquito Abatement Districts in Wisconsin.

William G Meyer, MD, Milwaukee, recently became associated with the medical staff of the Door County Medical Center at the Dr E C Farmer Clinic in Sister Bay. Doctor Meyer graduated from the University of Minnesota Medical School, Minneapolis, and completed his residency at Deaconess Hospital in Milwaukee.

Jeffrey Polzin, MD, Black River Falls, has joined the medical staff of the Krohn Clinic. He graduated from Mayo Medical School, Rochester, Minn, in 1978, and served his residencies at the Mayo Clinic, Zumbrota, and Kasson, Minn, and LaCrosse. Having a special interest in obstetrics, he has been a member of the Great Plains Perinatal Association since 1980.

David C Grout, MD,* Fort Atkinson urologist for 10 years, became the first medical practitioner ever to be named to Fort Atkinson Memorial Hospital as a trustee. He is serving a five-year term. He graduated from Ohio State University Medical School and served his internship and residency at Northwestern University Medical school.

Miles Krupka, MD, formerly of Wichita, Kansas, recently joined the medical staff of the Northwoods Hospital in Phelps. Doctor Krupka graduated from Abraham Lincoln School of Medicine at the University of Illinois, Chicago, and completed his internship at Cook County Hospital. His family practice residency was served at Fargo, North Dakota.

Jerome H Gundersen, MD and **Gregory H Mahairas, MD,*** LaCrosse, have been appointed instructors of obstetrics-gynecology on the faculty of Mayo Medical School, University of Minnesota. Doctor Gundersen joined the medical staff of the Gundersen Clinic, Ltd in 1967 and Doctor Mahairas in 1966.

Steven R Gambert, MD,* Milwaukee, recently was appointed assistant professor of medicine and director of the Gerontology and Geriatrics Service at the Medical College of Wisconsin. Doctor Gambert previously was a fellow in endocrinology and metabolism with Harvard Medical School, and a staff physician at Beth Israel Hospital in Boston. He graduated from Columbia University College of Physicians and Surgeons and was awarded the George Wiley Prize in Biology from New York University and the Joseph Goldberger Research Fellowship from the American Medical Association.

Robert K Gleeson, MD, Glendale, recently joined the Northwestern Mutual Life Insurance Co, Milwaukee, as assistant medical director. Since 1979 Doctor Gleeson was in private practice in Grand Rapids, Mich, and also had been an instructor in internal medicine at Michigan State College of Medicine. He graduated from Rush Medical College, Chicago, in 1975.

Leland C Pomainville, MD,* Wisconsin Rapids (right above) is shown receiving an engraved Golden House Clock from Elvio Misoni (left), who is sales representative of Abbott Laboratories. Abbott Laboratories presented the clock in commemoration of Doctor Pomainville's 50 years of outstanding service and dedication to medicine.

Elmer Rohde, MD,* Galesville, was honored at the May meeting of the Western Wisconsin Health Systems Agency for his contributions to health planning. Doctor Rohde, active in health planning since the late 1960s, has been a member of the Western Wisconsin Health Systems Agency since its inception in 1976. He was chairman of the Planning Committee and has served on the Executive, Roles and Relationships committees. He presently is a member of the committee which meets with legislators and health planning representatives from across the nation.

Donald R Griffith, MD,* Eau Claire, recently became the second Eau Claire resident to receive the Max Fox Preceptor Award given by the University of Wisconsin Medical School and Alumni Association. Doctor Griffith has been a preceptor for more than 20 years. The preceptor program was started in 1926.

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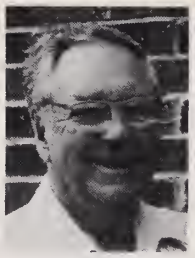

DOCTOR MURPHY

DOCTOR YEREX

DOCTOR REIMANN

James L Murphy, MD,* Park Falls, recently retired from active medical practice. Doctor Murphy was honored for his years of service to the community with a banquet and reception. He graduated from Marquette University School of Medicine, Milwaukee, and served his internship in Pittsburgh. He opened his medical practice in Park Falls in 1949 and in 1950 served in the United States Army Air Force for three years. He returned to Park Falls and practiced medicine until his retirement.

Leah A Reimann, MD,* pediatrician at the Gunderson Clinic, Ltd, LaCrosse, recently received a Medical Alumni Association Award for Distinguished Teaching for 1981. She was selected by vote of the University of Wisconsin medical students.

Joyce A Yerex, MD,* Racine, recently was named director of the Department of Radiology at Kenosha Memorial Hospital. Doctor Yerek has been on the medical staff of Kenosha Memorial Hospital since 1977 and succeeds William J Swift, MD,* Kenosha, who has directed the department for more than 30 years. Doctor Yerex is a native of Scotland. She earned her medical degree form St Andrews University there. She completed her residency in radiology at Columbia Hospital in Milwaukee in 1971.

Anthony V Pisciotta, MD,* Elm Grove, recently was appointed to a two-year term as director of research of the Radiation Effects Research Foundation in Hiroshima. He is on a leave of absence as professor of medicine at the Medical College of Wisconsin. Doctor Pisciotta graduated from Marquette University School of Medicine and has twice received the teaching award from the Medical College of Wisconsin in both preclinical and clinical divisions and was named "Alumnus of the Year" in 1977.

Thomas Salach, MD, Waterford, recently became associated with the Burlington Medical Center, Ltd, and has his medical practice in Waterford. Doctor Salach graduated from Notre Dame University Medical School and completed a rotating residency at Little Company of Mary Hospital in Evergreen Park, Ill.

John L Herlache, MD,* Sturgeon Bay surgeon associated with the Door County Medical Center, recently was presented with the first Louis Gorin Award for Outstanding Achievement in Rural Primary Care. The Rural Primary Care Association newsletter says Doctor Herlache was selected for the award "in recognition of the principles and uncompromising dedication guiding his efforts in the Sturgeon Bay area." Sponsors of the award are The Rural Primary Care Association and the American Medical International.

CES FOUNDATION

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for May 1981 and June 1981.

CONTRIBUTIONS—MAY 1981

Unrestricted

Manitowoc County Medical Society Auxiliary; Ashland-Bayfield-Iron County Medical Society Auxiliary; Walworth County Medical Society Auxiliary; Fond du Lac County Medical Society Auxiliary; EM Dessloch, MD; Kimberly Clark Foundation, Inc; Rusk County Medical Society; SMS Members—*Voluntary Contributions*

Restricted

Dr-Mrs FJ Hofmeister—*Student Loan Fund*

CESF—*Museum of Medical Progress*

Drs Crawford & McNeal, Green Bay—*Medical Student Summer Externship Program*

Leonard B Torkelson, MD; Alice Thayer—*Aesculap. Society Dues*

Sheboygan County Medical Society—*Sheboygan County Auxiliary Nursing & Allied Medical Careers Student Loan Fund*

Russell F Lewis, MD—*Aesculapian Society Dues (Museum of Medical Progress Endowment Fund)*

Robert L Van Dyken; Philip T Poullette; Philleo & Edith Nash; Ray A Johns; Kremers-Urban Company, Milwaukee; Francis J Daly, Sr—*LC Pomainville, MD Fund*

LaVerne Bartel; Mrs James Kuplic; John J Beck, MD; John A Harris, MD; Leonard B Torkelson, MD; Duane Taebel, MD; Edwin L Overholt, MD; Paul Cunningham, MD; Bruce J Stoehr, MD; George H Handy, MD; Roger L Ruehl, MD; Joseph M Jauquet, MD; Russell S Pelton, MD; Gerald Kempthorne, MD; George W Arndt, MD; AR Pequet, MD; Kermit Newcomer, MD; Jules D Levin, MD; KW Cosheen, CA Natoli, MD; Donald A Peterson, MD; Glenn Seager, MD; Mrs ER Thayer; Tom Rice, MD; Mrs Leonard B Torkelson; EM Dessloch, MD—*Museum of Medical Progress Endowment Fund*

Memorials

Mr-Mrs Earl R Thayer—*Art Steiner; Ann Adney; Mrs Judith Herman; Joseph Lubitz, MD (Museum of Medical Progress Endowment Fund)*

HB Maroney, II—*Joseph Lubitz, MD; Judy Herman (Barbara Scott Maroney Memorial Fund)*

Dr-Mrs Robert T Schmidt—*Mrs Lulu Hendrickson (Brown County Student Loan Fund)*

State Medical Society Auxiliary—*Elsie Wright*

Dr-Mrs EJ Nordby—*Mrs Albert Kalchbrenner*

David J Carlson, MD—*Robert Haukohl, MD*

Dr-Mrs HJ Kief; David J Carlson, MD; Vaughn Demergian, MD; Carl SL Eisenberg, MD; George H Handy, MD; M Thomas Chemotti, MD; Mark Liebow, MD; Gerald C Kempthorne, MD; Kenneth S Opin; Timothy H Lynch; Allan B Levin, MD; Roche-A-Cri Clinic; Chesley P Erwin, MD; Lois A Riley; GA Gehl, MD; Theodore C Fox, MD; JD Kabler, MD; Raymond C Zastrow, MD; Russell F Lewis, MD; Paul Jacobson; Richard W Biek, MD; John F Kreul, MD—*Joseph Lubitz, MD (Lubitz Fund)*

Ruth E Giulian—*Kenneth A Bevington*

CONTRIBUTIONS—JUNE 1981

Unrestricted

Marathon County Medical Society Auxiliary; Winnebago County Medical Society Auxiliary; Fond du Lac County Medical Society Auxiliary; LaCrosse County Medical Society Auxiliary; Eau Claire-Dunn-Pepin County Medical Society Auxiliary; Mrs Timothy Flaherty; SMS Members—*Voluntary Contributions*

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Merck & Company—*Speakers Service*

Putnam Heights Clinic, Eau Claire; Farrell Clinic, Prairie du Chien; Dr's Park Family Physicians, Platteville; Glen J Heinzel, MD; RM Neesemann, MD; Elmbrook Memorial Hospital, Brookfield; South Shore Family Medical, Milwaukee; Quisling Clinic, Melvin Rosen, MD; William C Woods, MD; Falls Medical Group, Menomonee Falls; Family Medical Clinic; Manitowoc Family Practice Association; Wisconsin Rural Rehabilitation Corporation; John S Honish, MD; David P Losh, MD—*Medical Student Summer Externship Program*

Mrs RW Edwards—*Aesculapian Society Dues*

Richard W Edwards, MD; Mrs Stephen Webster; Mrs Kermit Newcomer; Mrs K Alan Stormo—*Museum of Medical Progress Endowment Fund*

Leland Pomainville, MD—*LC Pomainville, MD Fund*

Memorials

Dr-Mrs Robert T Schmidt—*Dr Milton Perry Hunter; Mr James Hughes; Mr Andrew Sherman; Mr Thomas Bittner (Brown County Loan Fund)*

Diane Upton—*Richard Henry, MD (Student Loan Fund)*

Mr-Mrs Earl R Thayer—*Richard Henry, MD (Museum of Medical Progress Endowment Fund)*

Robert F Purtell Jr, MD; Albert J Motzel Jr, MD; Patricia Stuff, MD; Darold A Treffert, MD; James R Mattson, MD; James W Erchul, MD; Herman J Dick, MD; Dr-Mrs Wm T Russell—*Joseph Lubitz, MD (Lubitz Fund)*

David N Goldstein, MD—*Edgar End, MD; Richard A Henry, MD*

Dane County Medical Society—*Walter F Lappley, MD*

Mrs Joseph Lubitz—*William Grover, MD*

Herman J Dick, MD—*Dr Dick's Daughter Dixie*

Dr-Mrs Wm T Russell—*John T Sprague, MD*

State Medical Society—*Stephen H Ambrose, MD; Walter F Lappley, MD; Syrene CB Goldberg, MD; John J Rouse, MD; John D Charles, MD; Earl T Harrington, MD; Irvin L Slotnik, MD; Murray W Randall, MD; William B Walton, MD; Addis C Costello, MD; Paul F Doege, MD; Edward J Kerscher, MD; Thornton M Northey, MD; Otto G Rosemeyer, MD; Richard A Henry, MD; Joseph M Lubitz, MD* ■

Obituaries

✓County, State, and AMA members

✓**Dee William Dailey, MD,** 67, Elcho, died May 25, 1981 in Elcho. Born June 28, 1913 in Milwaukee, Doctor Dailey graduated from Loyola University Medical School, Chicago, in 1939. His internship was taken at Morningside Hospital, Tulsa, Oklahoma, and his residency was completed at Hillcrest Memorial Hospital in Tulsa. Doctor Dailey served in the United States Army Medical Corps during World War II. He had served as chief-of-staff at Langlade County Memorial Hospital and also had been president of Langlade County Medical Society. Surviving is his widow, Marion.

✓**Leo A Hoffmann, MD,** 87, Campbellsport, died June 12, 1981 in Campbellsport. Born Oct 8, 1893 in Campbellsport, Doctor Hoffmann graduated from Marquette University School of Medicine in 1917 and served his internship at Milwaukee Hospital. In 1967, Doctor Hoffmann was honored by the community of Campbellsport for his 50 years of medical service to the area. He also is a past president of the Fond du Lac County Medical Society. Surviving are his widow, Malinda; three sons, Arthur, Dallas, Tex; Dr William Phil, Hartford; and Math of Appleton; and three daughters, Mrs Geno (Jane) Scudella, Fond du Lac; Mrs Robert (Ruth) Hayward, Denver, Colo; and Mrs Clifford (Ann) Hale of West Bend.

✓**Edward J O'Neill, MD,** 78, Milwaukee, died June 13, 1981 in Milwaukee. Born Apr 8, 1903 in Milwaukee, Doctor O'Neill graduated from Marquette University School of Medicine in 1930 and completed his internship at Milwaukee County Hospital. He had served as chief-of-staff at St Francis Hospital, Milwaukee, and also for 15 years as medical director at Villa Clement Nursing Home in West Allis. Doctor O'Neill became a member of the "50 Year Club" of the State Medical Society of Wisconsin in 1980. Surviving are his widow, Helen; and two sons, James, Evanston, Ill, Thomas, Milwaukee; and one daughter, Mrs James (Peggy) Rogall, Milwaukee.

Raymond Paul Wiesen, MD, 75, Milwaukee, died June 16, 1981 in Milwaukee. Born May 1, 1906 in Milwaukee, Doctor Wiesen graduated from Marquette University School of Medicine in 1931. His internship was completed at St Joseph's Hospital in Milwaukee. Surviving are his widow, Caroline; three sons, Richard, Dennis, David; and two Daughters, Sharon and Holly.

✓**John A Booher, MD,** 75, Reedsburg, died June 17, 1981 in Franksville. Born Apr 3, 1906 in Sauk County, Doctor Booher graduated from the University of Wisconsin Medical School in 1931. He served his internship at Augustana Hospital in Chicago. Doctor Booher practiced in the LaValle and Reedsburg area from 1935 until his retirement in 1963. Surviving are two daughters, Mrs Nelson (Sandra) Powell, Franksville, and Mrs DuWayne (Sally) Jones of Reedsburg. ■

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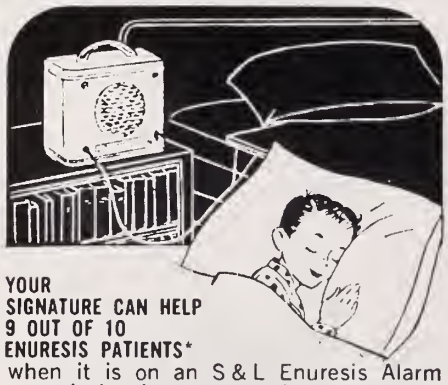

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Specialty Societies

*Physician members of State Medical Society of Wisconsin

American College of Physicians has released its comprehensive response to the final Graduate Medical Education National Advisory Committee (GMENAC) report. In approving the College's response, the ACP Board of Regents noted that:

> The adequacy of health manpower, in terms of quality, numbers and distribution, is both a professional and societal responsibility. The American College of Physicians recognizes its role in fulfilling its responsibility in this area. The College recognizes that government has a role in developing, collecting, and analyzing health manpower data. Any enterprise developed to act in this area should be one in which there is a joint participation between the health professions and government. The College holds that existing federal legislation is adequate to support this role and does not support additional legislation to expand the federal government's authority.

Copies of the ACP statement are available from the Division of Public and Professional Communications, American College of Physicians, 4200 Pine St, Philadelphia, Pa 19104.

Emergency Medicine Section of the State Medical Society of Wisconsin, which met March 28, during the SMS Annual Meeting, recently filed its minutes with the SMS Secretary. The secretary-treasurer, C Randolph Turner, MD* of Milwaukee reported that Thomas A Reminga, MD* of Milwaukee, who served as a delegate to the Department of Health and Social Services (DHSS) Emergency Medicine Committee concerned with categorization of emergency departments with the state, reaffirmed the Section's approval in principle of categorization of emergency departments but stressed that these categorizations should be done with pre-set criteria. This categorization of emergency departments would be instrumental in leading to eventual designation of certain centers into the six major areas such as cardiac trauma, neonatal, etc. The original plan was thought to be expensive in that it would take two people two days to review each hospital and there would be approximately 200 hospitals to be reviewed. This original categorization plan was reviewed by the Health Planning Commission of the SMS which concurred that the original plan be deferred. Suggestions were made that a questionnaire be sent and spot checks be made relative to these questionnaire findings. It was also suggested that this categorization be carried out with pre-set criteria using AMA guidelines proposed at the 1980 Annual Meeting.

In an appropriateness review by the DHSS six criteria were set similar to the ones proposed in 1976. Certain basic minimums would have to be met to be categorized as an emergency department. A general basic minimum classification would be that a physician would be on-call within 30 minutes of the emergency department. This is the first step in the possible decertification of certain emergency departments within a state.

The Section members agreed that next year's program be extended to two to three hours with possibly two speakers and no plans for a luncheon. The next Section meeting will be held May 15 as part of the 1982 SMS Annual Meeting. Frederick A Klemm, MD* of Wausau was named to represent the Section in the SMS Annual Meeting planning sessions. Herbert F Laufenburg, MD* of Milwaukee will take over final responsibility for the 1982 Section program.

The following officers and delegates were elected: Frederick A Klemm, MD,* Wausau, chairman; Gary L Gerschke, MD,* Milwaukee, vice-president; Joan M Gennrich, MD,* Milwaukee, secretary; and C Randolph Turner, MD,* Milwaukee, treasurer. Delegates named to the 1982 SMS House of Delegates are Eugene H Kastenson, MD, Elm Grove, delegate, and Herbert F Laufenberg, MD,* Milwaukee, alternate delegate. Richard J Krill, MD, Whitefish Bay, was named to serve as the Section's representative to the SMS Physicians Alliance Commission. Thomas A Reminga, MD,* Milwaukee, was asked to continue as the Emergency Medicine Section's representative to the DHSS Categorization Committee.

United States-Canadian Division of the International Academy of Pathology will hold its Annual Meeting at the Sheraton Boston in Boston, Massachusetts from Monday morning, March 1 through Friday evening, March 5, 1982. The Maude Abbott Lecture entitled "Soft Tissue Tumors in the 19th and 20th Century" will be delivered by Dr Raffaele Lattes on Tuesday, March 2. Further information about the meeting and courses may be obtained from Dr Nathan Kaufman, Secretary-Treasurer, United States-Canadian Division of the IAP, 1003 Chafee Ave, Augusta, Georgia 30904 (phone: 404/724-2973).

Wisconsin Society of Plastic Surgeons has reelected Vaughn Demergian, MD,* Madison to a second term as its president.

Wisconsin Academy of Family Physicians elected the following officers at its Annual Meeting. They are MDs Charles L Steidinger, MD,* Platteville, president; Jack Strong,* Mauston, president-elect; William E Wright,* Mondovi, secretary-treasurer; Robert F Purtell Jr,* Milwaukee, delegate, and John O Grade,* Elm Grove, alternate delegate. The Annual Meeting for 1982 is scheduled for the Raddison Hotel, LaCrosse, on June 17-20.

Milwaukee Opthalmological Society meeting speakers for the year 1981-1982 are as follows: Thomas D France, MD,* Madison, Oct 27; Walter Stark, MD, Johns Hopkins University School of Medicine, Baltimore, Md, Nov 24; Gregory Brinton, MD, Medical College of Wisconsin, Milwaukee, Jan 26, 1982; Juan Arensten, MD, Wills Eye Hospital, Philadelphia, Pa, Feb 23, 1982; and J A McCrary, MD, Baylor College of Medicine, Bellaire, Tx, Apr 27, 1982. The meetings are held at the University Club, 924 E Wells St, Milwaukee, Wis. ■

AMA PHYSICIAN RECOGNITION AWARD RECIPIENTS: January 1981

Azcueta, Cesar S, Milwaukee
Bangash, Jauhar A, Brown Deer
*Boland, Terrence W, Onalaska
*Carlson, Robert D, Marshfield
Chavez, Cesar T, Shullsburg
*Custer, Glenn S, Marshfield
*Damon, Richard A, Beaver Dam
*De Morest, Hugh F, Menasha
Farne, Rey F, Mauston
*Fischer, Markham J, Ashland
Frazin, Jared A, Madison
*Frisch, Robert A, Milwaukee
*Gerend, Jacob M, Sheboygan
*Glazier, Edward H, Waupaca
*Halbert, Helen E, LaCrosse
*Hanauer, Margaret M, Waukesha
*Hardacre, Jerry M, Marshfield
*Headlee, Raymond, Elm Grove
*Henderson, Robert R, Madison
Hepperla, Roger L, Elm Grove
*Hoffmann, William C, Hartford
*Hoyer, John K, Rice Lake
Huang, Chuong C, Milwaukee
*Hyndiuk, Robert A, Milwaukee
*Jackson, Pauline M, LaCrosse
*Keller, Theodore A, Menomonee Falls
*Kemper, Charles A, Chippewa Falls
*Kisken, William A, LaCrosse
*Kretzschmar, Hanns O, Appleton
*Kristensen, Lowell A, Rice Lake
*Lagus, Arne T, St Croix Falls
*Lindert, Merlyn C F, Milwaukee
*Lindesmith, Larry A, LaCrosse
*Listwan, William J, West Bend
*Lucas, George L, Madison
*Luck, Allan, Milwaukee
*Mahaffey, Howard W, Madison
*Marquis, Arthur S, Watertown
*Matzke, Rudolf W, Spooner
*Meighan, Pearse P, Appleton
*Morris, David L, LaCrosse
Murphy, Jerome V, Milwaukee
*Oberdorfer, Claude E, Racine
Park, Sootong, Milwaukee
*Paster, Robert M, Oregon
*Perlson, Samuel G, Milwaukee
*Peterson, Robert L, Waupaca
*Ping Jr, Er Chang, Oshkosh
*Rahimi, Abbas, LaCrosse
*Raschbacher, John L, Waukesha
*Rodriguez, Justo, Marshfield
*Rund, Carroll D, Menomonie
*Ruzicka, Francis F, Madison
*Sampica, Gerald J, Racine
Schmitz, Gerald L, Milwaukee
*Schwartz, Henry J, Woodruff
*Scott, C Malcolm, Superior
*Sherry, James J, Milwaukee
*Strebe, Kenneth L, Oconto Falls
*Terhorst, Thomas R, LaCrosse
*Teruel, Serafin B, Beloit
*Tiu, Alfonso L, West Allis
*Utz, Philip H, LaCrosse
*Van Pernis, Paul, Ashland
*Veit, Henry, Marinette
*Viel, Robert S, Brookfield
*Wells, Ronald K, Brookfield
*Wertsch, Paul A, Madison
*Zach, Robert G, Monroe
*Zellmer, Richard E, Milwaukee

AMA PHYSICIAN RECOGNITION AWARD RECIPIENTS: February 1981

Aussem, John W, Milwaukee
*Biehl, Mark D, Milwaukee
Cabreros, Helen R, Eau Claire
*Cervenansky, James M, Franklin
*Cohen, David A, Edgerton
*Conger, Charles, Wisconsin Rapids
*Davis, William E, LaCrosse
*De Koning, Joel R, Wausau
*Diefenbach, Eugene J, Hudson
*Doehlert, Charles A, Madison
*Edstrom, Lee E, Madison
*Erickson, Norman W, Beaver Dam
*Grace, Joseph B, Green Bay
*Hammond, Charles, Neenah
*Hinson, Robert E, Milwaukee
*Hoeper, Edwin W, Marshfield
*Huberty, Lee H, Kenosha
*Huebner, Timothy K, Wisconsin Rapids
Irani, Sohrab R, Burlington
*Janicek, Don R, Madison
*Kirchoffer, James B, Tomahawk
*Kirkham, Bruce C, Eau Claire
*Knepel, Donald, Janesville
*Koenig, Robert R, Milwaukee
*Kuhn, Raymond V, Oshkosh
*Kumar, R Pramod, Elm Grove
*Kwong, Roger W, LaCrosse
*Larme, Francis P, New Holstein
*MacDonald, Sanford D, Marshfield
*Martens, Jacob H, Wausau
McDermott, Raymond J, Hales Corners
*McKenzie, John R, Oshkosh
McMillen, Milton R, LaCrosse
*Milliken, Lyle D, Kenosha
*Miner, Edward B, LaCrosse
*Poley, Carl R, Green Bay
*Pulito, Frank J, South Milwaukee
*Ramlow, Robert W, LaCrosse
*Rasmussen, Nathaniel G, Dodgeville
*Russell, James C H, Ft Atkinson
*Schell, Charles A, Woodruff
*Spiegelhoff, Don R, Greendale
Strang, David J, Eau Claire
*Thompson, Teddy L, LaCrosse
*Tonkens, Samuel W, Milwaukee
*Wadhwani, Indur B, Racine
*Walker, James A, Menomonie

AMA PHYSICIAN RECOGNITION AWARD RECIPIENTS: March 1981

Alabarca, Nestor C, Lake Geneva
*Barrock, James J, Milwaukee
*Bartholmai, Jack R, Beaver Dam
Berger, Maury B, Milwaukee
*Block, Joel H, Wausau
*Davidson, Robert E, Eau Claire
*Detmer, Don E, Madison
Dorros, Gerald, Milwaukee
*Edland, Robert W, LaCrosse
*Graebner, Robert W, Madison
Gregory, Anthony R, Madison
*Hickey, Aloysius W, LaCrosse
*Kaske, Earl T, Madison
Lee, Sherman R, Menomonie
*Marlett, Myron M, Green Bay
*McDonough, John W (DO), Wisconsin Rapids
*Miller III, Charles H, LaCrosse
*Nelson, John M, Madison
*O'Connor, Thomas M, Milwaukee
*Otto, Samuel J, Milwaukee
Pearlman, Mary, Madison
Radius, Ronald L, Milwaukee
*Schleper, Albin J, Racine
*Simske, Clifford J, Wauwatosa
*Speichinger, James P, Madison
Taylor, Stewart F, Portage
*Troup, Charles W, Green Bay
*Turkington, Roger W, Brookfield
*Virata, Rodelino L, LaCrosse
*Winters, Kenneth J, Milwaukee
*Yllas, Santiago L, Racine
*Zimmers, Herbert J, Fox Point

*Members of the State Medical Society of Wisconsin

AMA PHYSICIAN RECOGNITION AWARD RECIPIENTS: April 1981

*Bahzad, Christobel G, Racine
*Barber, Jergen L, Waukesha
*Deiparine Jr, Alfonso B, Milwaukee
*Domnitz, Jeffrey M, Milwaukee
*Easom, Harry A, Milwaukee
*Garvida, Cesar A, Manawa
*Gehring, John V, Green Bay
*Gilbert, Francis, Kewaunee
Haselby, Ray Cloyne (DO), Marshfield
*Hirsch, Martin S, Eau Claire
*Keene, James S, Madison
*Koenig, Robert R, Milwaukee
*Lehner, Robert H, Racine
Maher, Laurine L, Wood
*Malloy, David J, Milwaukee
*Martin, John E, Green Bay
*Miller, Gerald J, LaCrosse
*Norman, Stanley G, Eau Claire
*Pulver, Nathaniel J, Madison
*Short, Howard W, Racine
*Shultz, Philip M, Madison
*Suits, John J, Marshfield
*Sullivan, John F, Beaver Dam
*Wood Jr, Fredrick, Kenosha

AMA PHYSICIAN RECOGNITION AWARD RECIPIENTS: May 1981

*Alvarez, Ubaldo A, LaCrosse
*Bender, Roger I, Beaver Dam
*Boyd, Andrew, Milwaukee
Brown, Richard E, Hales Corners
*Bruno, Domenick S, Milwaukee
*Cohen, Donald J, Milwaukee
*Corcoran, William A, Port Washington
*Daleiden, James P, Waukesha
*Dhuey, Joseph N, Milwaukee
*Diefenbach, Eugene J, Hudson
*Grinney, Leo R, Racine
*Gutglass, Milton F, Milwaukee
*Heersma, James R, Blue River
*Jacobson, Foster J, Milwaukee
*Kessler, Richard A, Stevens Point
*Martens, William E, Wauwatosa
Mirandilla, Rodulfo J, King
*Pansch, Donald J, Neenah
*Schuster, Donald S, Madison
*Schwartz, Walter R, Wauwatosa
*Shaffer, Richard L, Green Bay
Stien, Kim Patrick, Eau Claire
*Winston, Margaret C, Madison
*Wood, Michael T, Rhinelander

AMA PHYSICIAN RECOGNITION AWARD RECIPIENTS: June 1981

*Albrecht, James E, Jackson
*Albrecht, Paul G, Sparta
*Alexander, A Charles, Racine
Alsentzer, Ulrich K, Monona
*Arellano, Eduardo G, Waupun
*Barnes, Haldor Peter G, Wausau
*Behrend, Joseph F, Sun Prairie
*Behrens, Scott A, Neenah
*Beran, Frank V, Fort Atkinson
*Bernardoni, Robert J, Darlington
*Blink, Donald V, Eau Claire
Bostwick, Mark S, Port Washington
*Boyken, Mark E, St Croix Falls
*Brillman, Lester P, Beloit
*Brook, Jeffrey J, Sturgeon Bay
*Brummitt, Charles D, Oconomowoc
*Bryant, Richard J, Durand
*Bush, Curtis W, Beaver Dam
*Christianson, Richard E, Portage
*Christopherson, David L, Neenah
*Collins, Eugene G, West Allis
*Contreras, Mario T, Madison
*Cotts, Lloyd R, Rice Lake
*Crummy, Andrew B, Madison
*Dall, Glenn A, Milwaukee
*Damon, Richard A, Beaver Dam
*Derderian, Harry, Hubertus
*Derksen, Dirk J, Appleton
*Drozewski, Max F, Milwaukee
*Dukerschein, Franklin N, Oregon
Eid, Robert E, Madison
*Ellis, Richard L, Middleton
*Faber, John W, Neenah
*Flogstad, Duane L, Shell Lake
*Fox, Martin J, Wauwatosa
*Freeby, C William, Appleton
*Geigler, James E, Milwaukee
*Gersch, George P, West Salem
*Gissal, Frederick W, Wisconsin Dells
Gladitsch Richard E, Bloomer
*Gogan, Robert J, Mequon
Goletz, Ty H, Madison
*Gonzalez, Ramon A, Wauwatosa
*Grinney, June C, Racine
*Gungor, Bahri O, Neillsville
*Haight, Richard O, Appleton
*Haman, Kenneth L, Waupaca
*Hansen, Daniel R, Walworth
*Heinz, Harold N, Sheboygan
Heuer, Dale K, Milwaukee
*Hickey, C Hugh, Milwaukee
*Hillery, Glenn C, Lancaster
*Hoyer, John K, Rice Lake
*Hussa, John F, Hayward
*Janecek, Donald R, Madison
*Johnson, Gary A, Madison
*Johnson, Robert L, Wisconsin Rapids
*Jonas, Eugene R, Ellsworth
*Kangayappan, Sivikami, Manitowoc
Kapitan, Kent S, Madison
*Kemper, Charles A, Chippewa Falls
*Larkey, Jay A, Milwaukee
*Leer, Richard A, Marshfield
Leslie, Stephen W, Madison
Levin, Marc Richard, Milwaukee
*Liebenow, Roland R, Milwaukee
*Lindorfer, Donald B J, Milwaukee
*Lloyd, Baldwin E, Verona
Lukasek, Edward O, Sparta
*Luthra, Madhu V, Merrill
*Maasch, Lloyd P, Weyauwega
*Malewski, Larry J, Sheboygan
*Marasigan, Antonio Z, Hartford
*Marsho, Bernard S, Sheboygan
*May, James E, Milwaukee
*McClellan, Stephen L, Milwaukee
*McCullough, John C, Fond du Lac
*Meyer, Kilian H, Richland Center
*Moffat, Nelson A, Marshfield
*Morton, Luther J, Madison
*Moths, Robert W, Brookfield
Mundy, John C, Janesville
*Niehaus, Rebecca D C, Rhinelander
*Nielsen, William A, West Bend
*Nietert, William Clarkson, Mosinee
*Noble, John H, Black River Falls
*Nolan, James L, Waukesha
*O'Connor, Thomas A, Cudahy
Ostrov, Michael, Milwaukee
Owsiak, Andrew M, Milwaukee
*Pansch, Donald J, Neenah
Prensky, Jay G, Madison
*Raschbacher, John L, Waukesha
*Rasmussen, Nathaniel G, Dodgeville
Ridberg, Richard L, Milwaukee
Roberto, Frank A, Madison
*Rodriguez, Generoso N, New London
Rufino, Glicerio L, Brookfield
*Salan, Jerry R, Waupaca
*Sallis, Douglas A, Stanley
Sanchez, Romulo M, Cadott
*Schell, Charles A, Woodruff
*Schibly, William J, Green Bay
Schroeder, Norman C, Manitowoc
*Siefert, Clyde E, Oconto Falls
*Smirl, Warren G, Waukesha
*Sortor, Ralph F, Hales Corners
Stanley, Jerrel L, Milwaukee
*Stannard, Gilbert H, Manitowoc
*Steffan, Lloyd J, Plymouth
*Stone, Mildred M S, Cuba City
*Stuessy, Milton F, Platteville
Thorsen, Marie K, Wauwatosa
*Thune, Ronald G, Madison
Vantuyl, John R, Reedsburg
*Villavicencio, Celso A, Portage
*Weffenstette, Bruce E, Cedarburg
*Wells, Marin, Milwaukee
*Windeck, James L, Sheboygan
Wishau, James P, Lake Mills
*Wolfsmeyer, Waldemar W, Kaukauna ■

*Members of the State Medical Society of Wisconsin

News Highlights

*Physician members of State Medical Society of Wisconsin

Medical College of Wisconsin has reported that its family practice residency programs, along with community hospitals, are filling a need in the state.

Small cities in outlying areas of Wisconsin have gained 24 physicians from the first five graduating classes of the Medical College's Family Practice Residency Program. These physicians have set up practice in municipalities ranging from Prentice, population 598, to Ashland, population 8,980. They have also settled in Oconto Falls, Sister Bay, Burlington, New London, Park Falls, Hudson, Kewaskum, Ripon, Jackson, Chilton, Shawano, DeForest, and Pulaski.

In all, 73 (63%) of the 115 family physicians graduated from MCW's residency program have remained in Wisconsin. The program was established in 1974.

Six hospitals provide family practice training through the MCW program: Good Samaritan Medical Center-Deaconess campus, St Luke's, St Mary's, and St Michael, all in Milwaukee, Waukesha Memorial, and the Southeast Family Practice Center, a joint residency program beginning this July at St Catherine's Hospital in Kenosha.

Medical College of Wisconsin (MCW) Board of Directors, in May, unanimously passed a resolution at its annual meeting endorsing the decision of Milwaukee Children's Hospital to move to the campus of the Milwaukee Regional Medical Center. The Board felt Milwaukee Children's Hospital's decision was consistent with the overall goals and objectives of the Milwaukee County Medical Complex, the Froedtert Memorial Lutheran Hospital, and the Medical College to develop the region's tertiary care pediatric center. The MCW's Board also praised Milwaukee Children's plan for providing a primary ambulatory care facility for pediatric patients in the downtown area.

Jackson Foundation officials in Madison have announced the formation of the Health Forum speakers' bureau. Physicians, nurses, and other staff are available to speak to other health professionals, service clubs, conventions, church groups, business, industry, community, and professional groups. Presentations are designed to meet the needs and interests of the requesting organization. Topics range from highly technical and specialized information to general health care and health maintenance information and strategies. For further information and a complete listing of topics call or write the Foundation's Health Education Department located in the Jackson Clinic, 30 South Henry St, Madison, Wisconsin 53703 (phone: 608/252-8600).

Sacred Heart Rehabilitation Hospital, Milwaukee, recently was awarded a Certificate of Accreditation by the Joint Commission on Accreditation of Hospitals (JCAH). The hospital was evaluated during an on-site visit by a team of JCAH surveyors who conferred with the professional staff.

Jackson Clinic in Madison recently elected a new board of directors for one-year terms. Patricia A Joo, MD,* a pediatrician replaces John H Morledge, MD* as president. Others elected to the board are Klaus D Backwinkel, MD,* a general surgeon as first vice president; Barbara A Brew, MD,* an obstetrician-gynecologist as second vice president; Norval E Bernhardt, MD,* an otorhinolaryngologist as third vice president; D William Hurst, MD,* an internist as secretary; Harvey L Barash, MD,* an orthopedic surgeon as treasurer. Blake E Waterhouse, MD* continues as medical director. The Jackson Clinic has been serving Madison area patients for over 60 years. It now has three locations in Madison and is replacing the downtown clinic with a new structure under construction.

Jackson Clinic's medical director, Blake E Waterhouse, MD,* has announced the appointment of Michael R Rohr as clinic manager. Rohr was promoted from the position of business manager which he has held for the past ten years. Thomas M Hajewski has been appointed the clinic's finance director. Hajewski formerly held the position of manager of accounting for Wisconsin Power and Light. The Jackson Clinic is located in downtown Madison.

St Joseph's Hospital, Milwaukee, recently announced the election of William J Buggy, MD,* Wauwatosa, as president-elect of the medical staff. Doctor Buggy is presently a clinical professor in obstetrics-gynecology at the Medical College of Wisconsin, and has been a member of the hospital's medical staff since 1955. Chairmen of the departments are MDs William L Treacy,* Wauwatosa, Medicine; Bernard H Kampshroer, Brookfield, Radiology; and members-at large are Thomas P Driscoll,* Wauwatosa, Medicine, and William C Stewart,* Brookfield, Obstetrics-Gynecology.

St Joseph's Hospital, Marshfield, has named Sister Rita Adlkofer, RN, MSN, as its hospice care facilitator to coordinate present hospital-wide activities within the hospice concept, identify others, and serve as a resource person for members of the care-giving team. Sister Rita is a member of the hospital's sponsoring order (Sisters of the Sorrowful Mother), who has served as a staff nurse, head nurse, and supervisor in various settings and most recently was clinical nurse specialist, critical care. Sister Rita will provide a focal point for continued education, sharing, data gathering, and similar activities within the hospice concept. Although she is a member of the Nursing Service Department, Sister Rita will be available to every department and service area in the hospital, according to the hospital announcement. ■

Membership Directory UPDATE

Prepared from the June 23, 1981 Membership Report and from member notifications to Wisconsin Medical Journal for updating the 1980-81 Membership Directory published in the January 1981 issue.

Physicians are reminded that the newly revised Constitution and Bylaws, as adopted by the 1981 House of Delegates and printed in the June 1981 *Blue Book* issue, state that "any member whose current year's dues have not been received by the secretary of this Society by May 15 shall be deemed in arrears and his name shall be removed from the membership rolls of his county society and this Society until such time as full dues for the current year have been received." Reelected members are those physicians who previously were members. Reinstated members are those physicians removed from membership who have been returned to the roster without a break in membership.

ASHLAND-BAYFIELD-IRON

New members

IM ON
Cadwell, Frank J
2101 Beaser Avenue
Ashland WI 54806

BROWN

New members

TR R
Schlise, Sally M
1124 Cass St
Green Bay WI 54301

IM
Wampler, Robert E
1821 S Webster Ave
Green Bay WI 54301

Address changes

New	*Old*
FP GP **Rahr, Henry C** 346 Wagon Wheel Ct Green Bay WI 54302	832 Forest Hill Dr

Reelected members

PD PDA
Griggs, Stewart L
1821 S Webster St
Green Bay WI 54301

FP
Novotny, Clarence G
120 Siegler
Green Bay WI 54303

Reinstated members

OBG
Gallagher, Donald J
120 Siegler St
Green Bay WI 54303

COLUMBIA-MARQUETTE-ADAMS

Address changes

New	*Old*
PD HEM ON **Daneshbod-Skibba, Ghodsi** PO Box 1376 Englewood CO 80150	1511 Park Ave Columbus WI 53925

DANE

New members

P CHP
Bauer, Catherine M
2250 Keyes Ave
Madison WI 53711

ORS
Gencheff, Todor
2830 Dryden Dr
Madison WI 53704

IM AN
Coursin, Douglas B
B6/387 CSC
600 Highland Ave
Madison WI 53792

IM PH
Hunt, Vernon B
H4/416 CSC
600 Highland Ave
Madison WI 53792

IM
Elk, Robert L
600 N 8th St
Mt Horeb WI 53572

Address changes

New	*Old*
OBG **Barron, Cindy L** 130 Farrell St Madison WI 53714	5 Dunraven Court
AN **Boncyk, John C** 831 Bradley Ave Eau Claire WI 54701	5404 Mathews Rd Middleton WI 53562
OBG **Crumpacker, Margaret** 4940 Audubon Ave St Louis MO 63110	2065 Half Day Rd Deerfield IL 60015
OTO HNS **Erbach, Thomas J** 2180 Main St Wailuku Maui Hawaii	53 Merlham Dr Madison WI 53705
IM PUD **Lingenfelter, Mark S** 4701 Sheboygan Ave, #118 Madison WI 53705	5808 Baskerville Walke Middleton WI 53562
OS **Martyn, Kurt R** 1560 N Sandberg Tr., #1012J Chicago IL 60610	3702 Zwerg Dr Madison WI 53705
AN **Schmidt, Carl W** 4605 Hayes Rd Madison WI 53704	2321 Traceway Dr
OPH **Sondheimer, Stuart P** 1715 Norman Way Madison WI 53705	234 Randolph Dr
IM **Straughn, Robert A** 428 Lily Dr Madison WI 53713	263 Emporia San Antonio TX 78209

DANE continued

Address changes

New	*Old*
PTH **Wester, Susan M** 1230 Madison St LaCrosse WI 54601	229½ 8th Ave SE Rochester MN 55901

Reelected members

IM NEP
Wilson, Henry M
2453 Atwood Ave
Madison WI 53704

Reinstated members

IM **Hendricks, Richard J** 1912 Atwood Ave Madison WI 53704	P **Sheldon Jr, Edwin O** 2727 Marshall Ct Madison WI 53705

DODGE

New members

OPH
Davis, George E
130 Warren St
Beaver Dam WI 53916

DOOR-KEWAUNEE

New members

GS **Herlache, John L** 345 South 18th Ave Sturgeon Bay WI 54235	FP **Wake, Joan P** 1116 N 3rd St Sturgeon Bay WI 5423[5]

DR R
Wake, Brian D
1116 N 3rd St
Sturgeon Bay WI 54235

Reelected members

FP
McAuliffe, Edward P
345 South 18th Ave
Sturgeon Bay WI 54235

OBG GP
Wagener, Nicholas R
802 N 3rd Ave
Sturgeon Bay WI 54235

DOUGLAS

Address changes

New	*Old*
GP **Mc Ginnis, James P** 1653 Meadow Circle SE Rochester MN 55901	2438 19th Ave, NW

EAU CLAIRE-DUNN-PEPIN

Reinstated members

OBG
Hill, Eldon F
2125 Heights Dr
Eau Claire WI 54701

EAU CLAIRE-DUNN-PEPIN continued

Address changes

New	*Old*
IM **Fulks, Michael W** 325 Hewitt St Eau Claire WI 54701	2214 Peters Dr
GS **Rice, Theresa C** 5415 Sandy Grove Dr Kingwood TX 77339	2118 Skills Ave Eau Claire WI 54701

FOND DU LAC

Address changes

New	*Old*
IM **Kendell, William G** General Delivery Three Lakes WI 54562	1035 Mary Hill Park Dr Fond du Lac WI 54935

New members	*Reinstated members*
FP **Nelsen, Paul D** 669 Thorne St Ripon WI 54971	PD **Peterson, Clifton R** 92 E Division St Fond du Lac WI 54935

Deceased members

Hoffmann, Leo A—June 12, 1981

GREEN

New members

ORS
George, Jacob
1515 10th St
Monroe WI 53566

Reelected members

FP EM **Hein, William E** Durst Road New Glarus WI 53574	PD **Stiles, Frank C** 1515 10th St Monroe WI 53566

GREEN LAKE-WAUSHARA

Address changes

New	*Old*
FP **Osicka, Steve R** 310 Darling St Berlin WI 54923	PO Box 336 Redgranite WI 54970

KENOSHA

Address changes

New	*Old*
P N **Kappus, Harold C** 4126 Berryville Rd Kenosha WI 53142	4703 Brisa Del Norte Tucson AZ 85718

LA CROSSE

Address changes

New	*Old*
IM GE **Oliai, Asghar** 1081 Selke Rd La Crescent MN 55947	3160 Elm Dr LaCrosse WI 54601

Reinstated members

OTO PS
Ford Jr, Charles N
1836 South Ave
LaCrosse WI 54601

MILWAUKEE

Address changes

New	*Old*
GP **Asinas, Ildefonso L** 2745 W Layton Ave, #102 Milwaukee WI 53221	4359 S Howell Ave Milwaukee WI 53207
OTO **Kidder, Thomas M** 4019 E Allerton Ave Cudahy WI 53110	4404 W Oklahoma Ave Milwaukee WI 53219
D **Levenson, Ina G** 3800 South 27th St Milwaukee WI 53221	3168 S 27th St Milwaukee WI 53215
P **Mirassou, Marlene M** 304 Pine Rock Ave, #C-19 Hamden CT 06514	1983 N Summit Ave Milwaukee WI 53202
R **Moel, Morris** 821 Cypress Blvd, #207 Pompano Beach FL 33060	545 Oaks Lane Pompano Beach FL 33060
GS **Redlin Russell R** 6440 Briarwood Lane Waterford WI 53185	77-500 Interstate 10 Indio CA 92201
IM **Spector, Jack A** 2040 W Wisconsin Ave, #305 Milwaukee WI 53233	425 E Wisconsin Ave Milwaukee WI 53202
D A **Tibbetts, Palmer G** 8031 W Holmes Ave Milwaukee WI 53220	3800 S 27th St Milwaukee WI 53221
P **Soo, K Kwang** 2025 East Newport Ave Milwaukee WI 53211	111 E Wisconsin Ave Milwaukee WI 53202

Reinstated members

PD PUD **Bruns, W Theodore** 10425 W North Ave Milwaukee WI 53226	OBG **Coffey, John M** 9205 W Center St Milwaukee WI 53222

MILWAUKEE continued

Reinstated members

PD **Gupta, Jagdish C** 2388 North Lake Dr Milwaukee WI 53211	PD **Mitcham, Leroy** 2460 W Vliet St Milwaukee WI 53205
PTH **La Fond, David J** 2200 W Kilbourn Ave Milwaukee WI 53233	IM **Paz, Edward** 7205 Dorchester Lane Greendale WI 53129
PD **Mc Lean, Zarah G H** 2460 West Vliet St Milwaukee WI 53205	A **Weller, Ross R** 2600 N Mayfair Rd, #970 Milwaukee WI 53226

Removed from membership

Gupta, Ravi

Deceased members

O'Neill, Edward J—June 13, 1981

County society transfers

Malinowski, Rodney W	to: Racine
Wiegmann, Otto A	to: Waukesha

MONROE

Address changes

New	*Old*
GS U RET **Beebe, DeWitt C** RFD 2 Sparta WI 54656	202 South K Street
GP **Brown, Jack D** PO Box 250 Sparta WI 54656	202 South K Street

ONEIDA-VILAS

New members

PD
Kretz, Diane B
Eagle River WI 54521

CDS TS
Thomas, Quentin M
Eagle River WI 54521

Reinstated members

FP
Raduege, William E
Woodruff WI 54568

FP
Resan, Thomas K
PO Box 549
Woodruff WI 54568

OUTAGAMIE

New members

FP **Cherkasky, Alan H** 430 Brill St Kaukauna WI 54130	TR R **Kademian, Michael T** 424 E Wisconsin Ave Appleton WI 54911

Address changes

New	*Old*
D **Luther, Thomas W** 215 S State St Appleton WI 54911	PO Box 474

RACINE

Address changes

New	*Old*
PS GS **Malinowski, Rodney W** 4606 W Johnson Ave Racine WI 53405	821 N 117th St Wauwatosa WI 53226

County society transfers

Malinowski, Rodney W from: Milwaukee

ROCK

New members

IM
Frazer, Samuel L
580 N Washington St
Janesville WI 53545

Address changes

New	*Old*
D **Levin, Harlan M** 1 S Main St, #6 Janesville WI 53545	236 South Harbor Dr Venice FL 33595

Reelected members

PD
Nagle, Bruce K
580 N Washington St
Janesville WI 53545

OBG
O'Brien, James N
580 N Washington St
Janesville WI 53545

IM
Sargeant, Thomas S
580 N Washington St
Janesville WI 53545

OBG
Spooner, Myron G
1905 Huebbe Parkway
Beloit WI 53511

A IM
Wiseman, Terrance L
580 N Washington St
Janesville WI 53545

SHAWANO

New members

GP
Tauke, Ralph E
Tigerton WI 54486

SHEBOYGAN

Address changes

New	*Old*
AN EM **Hass, Richard A** 11107 N Lake Shore Lane Mequon WI 53092	4517 Pheasant Lane Sheboygan WI 53081

TREMPEALEAU-JACKSON-BUFFALO

New members

FP
Adams, Reuben J
1933 Park St
Whitehall WI 54773

FP
Mintek, Rian D D
Arcadia WI 54612

FP
Miller, Robert J
Arcadia WI 54612

Reelected members

PD
Selkurt, Joanne A
Whitehall WI 54773

VERNON

New members

FP
Devitt, Timothy J
RFD 1
Soldiers Grove WI 54655

FP
Ender, Carl A
PO Box 65
De Soto WI 54624

WAUKESHA

New members

US
Arenberg, M E
434 W Madison St
Waukesha WI 53186

FP PTH
Bamrah, Paramjit K
915 E Summit Ave
Oconomowoc WI 53066

US
Donovan, Michael E
434 W Madison St
Waukesha WI 53186

FP
White, Herbert C (DO)
W312 S4272 Highway 83
Genesee Depot WI 53127

CD IM
Gomez, Gustavo
16325 Shore Line Dr
Brookfield WI 53005

Address changes

New	*Old*
PTH CLP **Schamberg, Jay F** W180 N8085 Town Hall Menomonee Falls WI 53051	S47 W22060 Lawnsdale Waukesha WI 53186

Reinstated members

PD
Thomas, Elaine M
150 South Calhoun Rd
Brookfield WI 53005

FP
Zarbock, Floyd M
S89 W22915 Maple St
Big Bend WI 53103

County society transfers

OPH
Wiegmann, Otto A from: Milwaukee
17050 W North Ave
Brookfield WI 53005
(414) 786-0610

WINNEBAGO

Address changes

New	*Old*
GS **Isom, Robert G** 400 Ceape Ave Oshkosh WI 54901	650 Doctors Court
ORS **Schmitz, Peter W** 2441 Forestmanor Court Neenah WI 54956	768 Manchester Rd
GS **Smith, Frederick H** 235 Grant St Neenah WI 54956	116 S Commercial St, #119

WOOD

Address changes

New	*Old*
IM **Johnson, Gary A** 2509 Homestead Rd Madison WI 53711	1000 North Oak Ave Marshfield WI 54449 ■

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Blue Book–Update

IN THE LISTING on page 78 of the June 1981 Blue Book, under county medical societies, the following changes should be made:

LaCrosse: P—George P Gersch, MD
341 West Gardland St
West Salem WI 54669

Manitowoc: P—Thomas A Keller, MD
21st & Western Ave
Manitowoc WI 54220

Monroe: S—Jack D Brown, MD
PO Box 250
Sparta WI 54656

Oneida-Vilas: S—Daniel L Johnson, MD
Rte 1, Box 705
Rhinelander WI 54501

Ozaukee: P—M Thomas Chemotti, MD
N94 W6539 Fieldcrest
Cedarburg WI 53012

S—Thomas J Shewczyk, MD
W62 N563 Washington Ave
Cedarburg WI 53012

Winnebago: P—M James Simonson, MD
400 Ceape Ave
Oshkosh WI 54901

On page 69, under the First District, the address of Carl S Eisenberg, MD is, Post Office Box 17300, Milwaukee WI 53217.

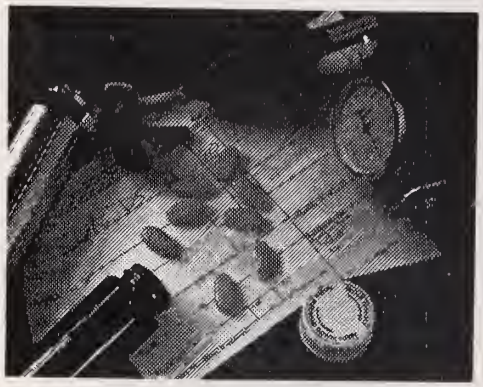
On page 72, under the Commission on Governmental Affairs, the new section representatives are as follows: Surgery, George F Flynn, MD, Milwaukee; Pathology, Harry J Zemel, MD, Fond du Lac; Physical Medicine and Rehabilitation, Neal Taylor, MD, LaCrosse.

On page 74, Charles L Steidinger, MD, Platteville, has replaced Richard K Chambers, MD as the representative to the Physicians Alliance Commission for the Family Physicians Section.

On page 75, under the Committee on Maternal and Child Health, the following changes should be made in the Subcommittee (Study Committee on Maternal Mortality Survey). Ben M Peckham, MD is no longer a member and new committee members are: MDs William E Martens and Everett A Beguin of Wauwatosa and LaCrosse, respectively.

On page 80 under the Officers of Specialty Sections of the State Medical Society, the alternate delegate for the Section on Emergency Medicine is Herbert F Laufenberg, MD, N70 W6874 Bridge Rd, Cedarburg 53012. ■

GOOD NEWS FOR DOCTORS



If you want a busy practice with no office overhead and little paperwork, then consider becoming a member of the Air Force health care team. You'll find medicine can be a great way of life in the Air Force. We can restore much of the satisfaction to your medical practice because we emphasize patient care instead of paperwork. We even provide professional liability protection under the Federal Tort Claims Act at no cost to you. And your income won't stop should you decide to take your family on vacation. We give you 30 days of vacation with pay each year.

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or
TSgt. Mike Kurth
2457 N. Mayfair Road
Suite 204
Wauwatosa, WI 53226
(414) 258-2430

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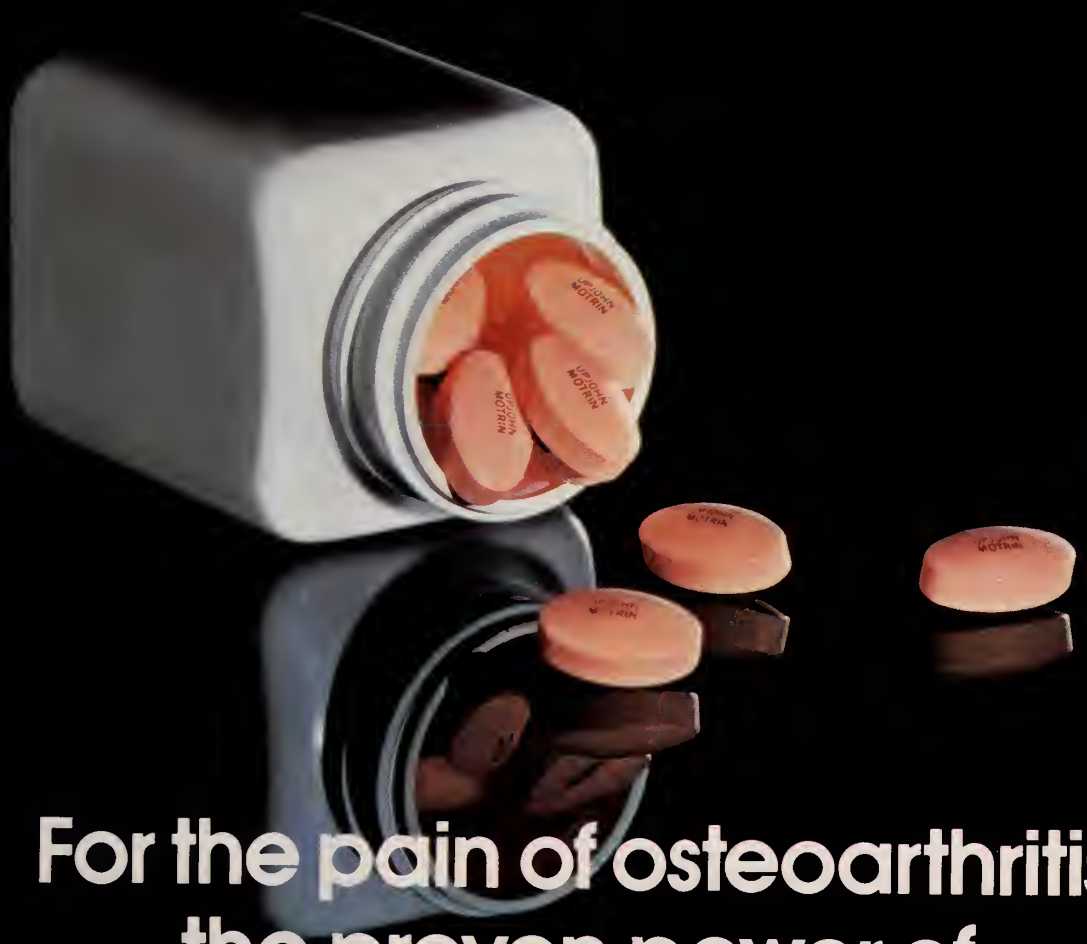

For the pain of osteoarthritis the proven power of

Motrin®

ibuprofen, Upjohn

600 mg Tablets

One tablet t.i.d.

Please see the following page for a brief summary of prescribing information.

Upjohn

Motrin® Tablets (ibuprofen, Upjohn)

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents. Anaphylactoid reactions have occurred in such patients.

Warnings: Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. *Motrin* should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If *Motrin* must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity characterized by papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin*.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* and the patient should have an ophthalmologic examination, including central visual fields and color vision testing **Fluid retention and edema** have been associated with *Motrin;* use with caution in patients with a history of cardiac decompensation or hypertension. *Motrin* is excreted mainly by the kidneys. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* safety in patients with chronic renal failure have not been done. *Motrin* can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy. Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema. To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* is added. The antipyretic, anti-inflammatory activity of *Motrin* may mask inflammation and fever.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.

Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal, of which one or more occurred in 4% to 16% of the patients.

Incidence Greater Than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence Less Than 1%—Probable Causal Relationship*

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence Less Than 1%—Causal Relationship Unknown*

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schonlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship" (PCR)* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Do not exceed 2400 mg per day. If gastrointestinal complaints occur, administer with meals or milk.

Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Caution: Federal law prohibits dispensing without prescription.

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July 1981

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Medical Yellow Pages

RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

Wanted. Family Physician to associate with four family physicians and two general surgeons to work in a satellite clinic 12 miles from Fond du Lac, Wis. Fond du Lac is a community of 37,000 located on Lake Winnebago in the heart of Wisconsin's agricultural and recreational area, 60 miles from Milwaukee, Green Bay, and Madison. Rotation of night and weekend call with four family physicians with two month vacation and study per year. 300-bed hospital. Excellent schools, four year liberal arts college, two year University of Wisconsin extension. Contact: John U Peters, MD, 505 East Division St, Fond du Lac, Wis 54935. Call collect: 414/922-3700 (business phone); 414/922-7899 (home phone). 6-8/81

Family Physician wanted to develop solo practice with possibility of association with medical group. Clinton, Wisconsin, a progressive and prosperous farm area. Will provide financial assistance with first-year guarantee income negotiable. May build or rent office. 256-bed hospital affiliation located within 10 miles. Ideal family-oriented community with excellent schools, economy, and recreation. Easy access to Chicago, Milwaukee, Madison, and Rockford. Other doctors available for backup/vacations. Contact S Rudolph, Beloit Memorial Hospital, 1969 West Hart Rd, Beloit, Wis 53511; 608/364-5104. 6-8/81

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Board certified or eligible family practitioners, OB-GYN and surgeon wanted to join expanding multispecialty group located in South Central Wisconsin near major metropolitan area. Excellent salary structure and benefits first year with options thereafter. Interested physicians inquire immediately. All requests to be answered immediately and in confidence. Write Dept 488 in care of the Journal. 5tfn/81

PRIMARY CARE PHYSICIANS
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We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

p1-12/81

Internist, with or without a subspecialty, wanted to join Milwaukee Internal Medicine Group. First-year salary negotiable. Opportunity to join corporation. Excellent fringe benefits and retirement plan. Contact: Administrator, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 7-9/81

General and vascular surgeon, FACS, Board certified, highly qualified, with several years of practice, would like to join an individual or group with an established practice in metropolitan Milwaukee area. Contact Dept 493 in care of the Journal. 7tfn/81

Fifty-physician multispecialty clinic in West Central Wisconsin wants family practitioner for nearby satellite office, allergist, cardiologist (non-invasive), neonatologist, orthopedic surgeon, otolaryngologist, psychiatrist, pulmonary disease internist. Excellent cultural, education, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepsen, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54702 or call 715/839-5266. 7-9/81

Psychiatrist, American-born and trained wants to affiliate with multispecialty group in Milwaukee area. Hard working. Prefers incentive arrangement. Skilled in all modalities and comfortable with team approach. Call 414/774-4400. 8/81

Physicians available. Situations requested for practice opportunities in both solo practice and in group and clinics: *Obstetrician; Pediatrician; Internist; Surgeon; Anesthesiologist.* Call Dr Robb Montgomery, Director of Services in Physician Placement Assistance, Medi-Search, 918/481-0539, 8117 S Harvard, Tulsa, OK 74136. 8/81

Full-time medical director needed for busy plasmapheresis center. Excellent pay and benefits. Ideal for retired or semi-retired persons. Inquire Associated Bioscience of Madison, Inc, 515 N Lake St, Madison, Wis 53703. Ph 608/258-8288. 6-8/81

Tuition Assistance Program, Inc, PO Box 6221, Duluth, MN 55806. Matching communities seeking physicians with physicians-in-training requiring tuition assistance. Keith Hummel, Director. Write for more information. 8/81

MEDICAL DIRECTOR. Rapidly expanding mental health center in need of a Medical Director who would be responsible for the administration of medical care and the medical treatment of all patients of the Center. Specific duties will include organization and performance of the Quality Assurance Program, preventative and consultative services, medical records supervision, provision of medical evaluations, scheduling of psychiatric time for case staffing, and 24-hour psychiatric coverage. Excellent opportunity for a dynamic psychiatrist interested in community mental health and seeking a challenge. Applicants must be Board Certified or Eligible in psychiatry and licensed in the State of Indiana. Must have successfully completed a 3-year residency approved by the American Board of Psychiatry and Neurology. At least 2 years experience in related field and/or experience working with a multidisciplinary staff is preferred. Send resume to: Glenn A Kuipers, Center Director, Tri-City Community Mental Health Center, 3901 Indianapolis Blvd, East Chicago, IN 46312. An Equal Opportunity Employer. 8/81

Physicians Exchange

continued

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties. *Anesthesiology, Family Practice, Hematology/Oncology, Neurology* and *Otolaryngology.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K. L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 7tfn/81

Racine Medical Clinic, multispecialty group of 22 physicians has a practice association for internist. The clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406. Phone 414/886-5000. 5tfn/81

DIRECTOR, GRADUATE EDUCATION. The Department of Family Practice, The Medical College of Wisconsin, seeks a Board Certified Family Practice physician who will provide direction to six Family Practice Residency Programs (114 residents) in areas of curriculum, teaching development, evaluation and other special projects. Individual must give evidence of achievement and leadership; demonstrate effectiveness as a teacher; is knowledgable about residency program management; and maintains current clinical skills. This is a newly created position. Please direct inquiries to Thomas F Garland, MD, Acting Chairman, Dept of Family Practice, The Medical College of Wisconsin, Seton Tower, 2315 North Lake Drive, Milwaukee, Wis 53211. The Medical College of Wisconsin is an Equal Opportunity Employer. 8-9/81

Locum Tenens Opportunity in Family Practice

Immediate opening for doctor seeking Locum Tenens arrangement in Family Practice. The attractive clinic/hospital practice, located in Stanley, Wisconsin, is a rural satellite facility of Marshfield Clinic. Current staff comprises two full-time, Board Certified physicians who share call with two other physicians in adjacent community. To discuss this opportunity contact Frederic P Wesbrook, MD, Marshfield Clinic, 1000 North Oak Ave, Marshfield, WI 54449. 8/81

URGENTLY WANTED. GENERAL SURGEON Board Eligible or Certified to join nine-member multispecialty practice in North Central Wisconsin. Competitive salary plus full fringe benefit package. Excellent outdoor recreational area, fishing, hunting, camping, skiing. Send CV or contact Gary Quammen, Clinic Manager, The Medford Clinic, 101 Gibson Ave, Medford, WI 54451, or call area code 715/748-2121. p8/81

Initial practice or relocation possibilities in central Wisconsin for independent practitioners (family practice and specialties). Facilities available in new professional building located across from major medical complex. Personally tailored finished space. Support from established physicians. Contact: Dr E C Muehlenbeck and/or Wergin Realty, Inc, 2800 Westhill Dr, Wausau, Wis 54401; ph 715/848-1344. 7-8/81

Internist wanted, with or without subspecialty, to join long established private practice in Southeastern Wisconsin community of 75,000. Superb hospital facilities, totaling 600 beds. Excellent schools, University, and College facilities. Easy access to Milwaukee and Chicago. Position available now. Call collect 414/654-4562. 8-11/81

Family Practitioner or Internist to join 3-man group in Northern Wisconsin locale offering year-round outdoor activities. Clinic located close to 70-bed general hospital. Partnership first year. Attractive fringe benefits. Contact N L Bugarin, MD, Family Clinic, SC, 221 E Washington Ave, Tomahawk, Wis 54487; ph 715/453-2147. 7tfn/81

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

CompHealth—Locum Tenens. Physicians covering physicians, nationwide, all specialties. We provide cost-effective quality care. Call us day or night. T C Kolff, MD, President, CompHealth, 175 W 200 S, Salt Lake City, Utah 84101; ph 801/532-1200. p7-10/81

Marinette, Wisconsin needs a neurologist, otolaryngologist, second orthopedist, and obstetricians. Office space available. Please contact Kenneth H Yuska, MD, phone 715/732-1746. 7-8/81

Emergency Physicians. Full-time openings for ER physicians with group serving hospitals in Manitowoc, Sheboygan, Wisconsin Rapids, Shawano, Oconto Falls, and other cities. Excellent starting salaries, flexible schedules. Must be willing to relocate to area. Send CV to: Central States Emergency Physicians, PC, 1846 Hoffman St, Suite 101, Madison, Wis 53704 or ph 1/800-362-7366. 7-12/81

Family Practice Physician sought for affluent small town with excellent social, retail, and educational resources. Easy access to year-round outdoor activities and to Chicago and Rockford for social and professional opportunities. For the family man with ambition for a successful practice.

Contact: Harvey Pettry, Administrator
Highland Hospital
1625 S State St
Belvidere, IL 61008
815/547-5441 6-8/81

Obstetrician-Gynecologist, Board certified or eligible, to join 13-physician multispecialty group in metropolitan Milwaukee. Community of 31,000 offers excellent cultural, educational, and recreational facilities. Guaranteed first-year salary plus incentive. Ownership and comprehensive fringe benefit program available after one year. Send CV or inquiries to: PO Box 97, Butler, Wis 53007. 7tfn/81

Orthopaedic surgeon. Board eligible or certified to join established orthopaedist in central Wisconsin community of 18,000 with 36,000 service area. Progressive practice. Modern, well-equipped, 126-bed hospital. Excellent schools. Ideal family community. Salary open. Contact Dr McDonough, Riverview Hospital Medical Office Building, 400 Dewey St, Wisconsin Rapids, Wis 54494. Phone 715/421-5257 office; 715/325-2421 home. 7-9/81

Family Practice. General Clinic—Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 23-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 2tfn/81

Obstetrician-gynecologist wanted as an associate for an established practice in a desirable area of Milwaukee. Salary guarantee and other benefits provided. Contact Ashok Chatterjee, MD, 8511 West Lincoln Ave, Milwaukee, Wis 53227. Tel 414/543-9580. 7tfn/80

Pediatrician to join 3-BC pediatricians in city of 50,000. Good hospital with specialties well represented. Good schools, recreation with many lakes, university. Address replies with CV to: John B Hughes, MD, Oshkosh Children's Clinic, 645 Doctors Court, Oshkosh, WI 54901. 8-10/81

Wanted: Neurologist, Board certified or eligible, to join solo incorporated neurosurgeon in North Central Wisconsin. Send resume to: 425 Pine Ridge Blvd, Suite 301, Wausau, Wis 54401. 7-8/81

Two Family Practice Physicians sought to assume a fully operational practice in a community 30 miles north of Madison, Wisconsin. New clinic facility. Income guaranteed. Physician back-up available. Board certified or eligible preferred. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 5tfn/81

Milwaukee Internal Medicine Group wishes to share office space with any medical specialty in its well-equipped satellite office. Contact: Administrator, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 7-9/81

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

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Phone: (608) 222-2927 *Licensed Employment Agency*

Emergency Medicine Opportunities. Directorship and clinical positions available in the greater Milwaukee area. Excellent income, paid malpractice insurance, and flexible scheduling provided. For details, send credentials in confidence to Michael Dixon, 970 Executive Parkway, St Louis, MO 63141; or call toll-free 1/800-325-3982. 5-10/81

Ophthalmologist to join the Wilkinson Clinic, SC, a multispecialty group of 16 physicians located in lake country between Milwaukee/Madison. Excellent hospital, schools, and recreational facilities. Full fringe benefit package. Contact: David O Ulery, MD, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 7tfn/81

Internist wanted to join a 14-physician multispecialty group in one of northern Wisconsin's finest recreation areas. Modern 109-bed hospital. Excellent professional and personal opportunity. Contact Dr J Wiesner, Lakeland Medical Associates Ltd, Box 549, Woodruff, Wis 54568 or call 715/356-3292. 5tfn/81

Physicians wanted. For immediate openings in many Sunbelt and Midwest practices and clinics. Salaries and benefits excellent for: *Family Practice, Anesthesiology.* Call Dr Robb Montgomery, Director of Services in Physician Placement Assistance, Medi-Search, 918/481-0539, 8117 S Harvard, Tulsa, OK 74136. 8/81

Family or General Practitioner wanted at small town clinic in NW Wisconsin within one hour of Duluth. Rural area offers fishing, boating, hunting, skiing. Fully equipped clinic and support staff provided. Salary plus benefits and/or net income split. Send resume to WH Erskine, NWMC, Box 86, Minong, WI 54859; or call 715/466-2201. 8tfn/81

Practice opportunities for: *Opthalmologist, Neurologist, Psychiatrist, Family Practice (satellite locations). Internal Medicine w/subspecialty (except Gastroenterology).* Board eligible or board certified, to join 50-man multispecialty practice in southern Wisconsin, 45 minutes to Madison, two hours to Milwaukee. Perfect location for good family living. Contact: R E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566 or ph 608/328-7000. 7-9/81

Duke trained general psychiatrist with strong interest in psychotherapy wishes to relocate in midwest (Wisconsin). Board certified. Contact James L Gallagher, MD, 2219 Mont Haven Dr, Durham, NC 27712. Phone 919/383-4477 (home); 919/471-3487 (office). 8/81

Medical Facilities

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

For Sale: Hamilton examining room table and matching cabinet. Like new. Phone: 414/453-6432, Milwaukee. 8tfn/81

Milwaukee Suburb Family Practice available near Elmbrook Hospital. Low time commitment, yet nets over 50k per year. Donald Wood, MD, 17400 North Ave, Brookfield, Wis 53122; ph 414/786-5400. 8-11/81

Wanted. Used x-ray equipment, accessories, diathermy and ultrasonic units. Call 414/444-7125. 7-9/81

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special Issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1980 through Aug 31, 1981.

WISCONSIN

SEPTEMBER 8, 1981: Wisconsin State Medical Golf Association's Fall Tournament and Annual Meeting, Merrill Hills Country Club, Waukesha. Tee-off times start at 9:00 am until 1:30 pm. Info: Ronald Oschman, Secretary, WSMGA, 401 West Michigan, Milwaukee, Wis 53201; ph 414/266-6151.

SEPTEMBER 10-11, 1981: *New Drugs for the 80s and Aging and Its Problems,* Radisson Hotel, LaCrosse. Annual meeting cosponsored by the Wisconsin Society of Internal Medicine and American College of Physicians. AMA credit Category 1. Info: Kim J Marggraf, WSIM, 611 East Wells St, Milwaukee; ph 414/276-6445.

SEPTEMBER 11-12, 1981: *Seminars in Pediatrics,* University of Wisconsin Clinical Science Center, Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Pediatrics; and University of Wisconsin-Extension, Department of Continuing Medical Education. AMA credit Category I; AAFP pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

SEPTEMBER 17-19, 1981: *Infectious Diseases,* Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Medicine; and University of Wisconsin-Extension, Department of Continuing Medical Education. AMA Credit Category I; AAFP and AOA credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

SEPTEMBER 18-20, 1981: Fall Meeting, Wisconsin Society of Anesthesiologists, Lake Lawn Lodge, Delavan.

SEPTEMBER 23-26, 1981: *6th Annual Nuclear Cardiology Symposium,* Milwaukee. Sponsored by Mount Sinai Medical Center, Milwaukee; and University of Wisconsin-Extension, Department of Continuing Medical Education; University of Wisconsin School of Medicine, Milwaukee Clinical Campus, Cardiovascular Disease Program; American Heart Association; and Society of Nuclear Medicine. AMA Category I; UW Continuing Medical Education Units; VOICE. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

SEPTEMBER 25-26, 1981: *The High-Risk Patient with Dental Problems,* Madison. Sponsored by University of Wisconsin-Extension, Department of Continuing Medical Education; University of Wisconsin, School of Medicine; and Wisconsin Chapter, Academy of General Dentistry. Credit: University of Wisconsin Continuing Education Hours; Fellowship and Mastership credit, Academy of General Dentistry. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706, ph 608/263-2856.

MIDWEST CANCER SEMINAR
Madison, Wisconsin
September 17-19, 1981

For physicians from the midwestern states who are engaged in primary care and oncology-related specialties.

Sponsored by the Wisconsin Clinical Cancer Center-University of Wisconsin-Madison.

Objectives: To bring to the practicing physician current knowledge regarding screening, diagnosis and management of major malignancies.

Program: Sixteen visiting faculty from throughout the United States and Europe will participate.

ACS-WCCC Fall Cancer Conference: Saturday morning, September 19. UW-UCLA football game in afternoon.

Location: All sessions will be held at the Concourse Hotel.

CME Credit: 18 credit hours

Information: Contact Paul C Tracy, MD, telephone: 608/263-3455 or 263-2855.

7-8/81

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
1992—Apr 23-25	

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

SEPTEMBER 30-OCTOBER 2, 1981: *Third Great Lakes Conference on High Blood Pressure Control,* at Milwaukee Marriott Inn, Brookfield. Conference focus will be on the high risk and hard to reach individuals. Topics to be covered: medications management, strategies for the older adult population, patient compliance, pediatric management and operation of comprehensive community high blood pressure control programs. Registration is open to anyone interested in high blood pressure control. Cost: $40 prior to September 18 and $50 after September 18. One CME Category 1 credit towards Physician's Recognition Award of AMA and the American Heart Association will be offered for each hour of participation for a maximum of 10. CEUs also will be available. Great Lakes region includes the states of Wisconsin, Minnesota, Illinois, Indiana, Ohio, and Michigan. Conference is sponsored by Wisconsin Department of Health and Social Services and American Heart Association of Wisconsin. Info: Audrey Koehn, Wisconsin High Blood Pressure Control Program, PO Box 309, Madison, WI 53701.

OCTOBER 9-10, 1981: *Wisconsin ACEP/EDNA Fall Symposium,* at Pfister Hotel in downtown Milwaukee. National faculty. Further info: Gary L Gerschke, MD, 2025 East Newport Ave, Milwaukee, Wis 53211, or phone 414/961-3508. Credit: 12 hours CME, $60 Wisconsin ACEP members, $125 for nonmembers.—Wisconsin Chapter/American College of Emergency Physicians.

OCTOBER 9-10, 1981: Wisconsin Chapter, American College of Emergency Medicine, Pfister Hotel, Milwaukee.

OCTOBER 9, 1981: *Ophthalmology for the Primary Care Physician,* Madison. Sponsored by University of Wisconsin, School of Medicine, Dept of Ophthalmology; and University of Wisconsin, Extension, Dept of Continuing Medical Education. AMA Category 1; AOA and Family Practice credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706; ph 608/263-2856.

25th ANNUAL MEETING
American Association of Medical Assistants, Inc
SEPTEMBER 19-26, 1981
Hyatt Regency Hotel—Milwaukee
Host: Wisconsin Society-AAMAI
Theme: *Today's silver—tomorrow's gold*

Welcome party: Sunday evening, September 20, to share a bit of Wisconsin "gemutlichkeit" in a beer garden atmosphere

Official convention opening: Monday evening, September 21, with opening session of House of Delegates

Formal dinner: Wednesday evening, September 23, with awarding of certification pins and certificates to those who have successfully completed the national Certification Examination this past year.

Many interesting educational sessions and workshops throughout the week, along with organizational information and meetings

Between times there will be exhibits from many professional groups to visit, and the Arts and Crafts from many members to view

Inaugural banquet: Friday, September 25, when presidents of all the State Societies are introduced in the Parade of Presidents, highlighting the past 25 years, and new officers installed

General Chairman: Alice Budny
Vice Chairman: Carol Jean Beaver, RT

For registration blanks, write: American Association of Medical Assistants, Inc, One East Wacker Drive, Suite 2110, Chicago, Illinois 60601; or phone: (312) 944-2722

OCTOBER 14-17, 1981: *Wellness and Cardiovascular Health Symposium,* in celebration of the 10th anniversary of the LaCrosse Exercise Program. Involving: Adult Fitness, Patient Education, School Fitness, Exercise Testing, Community Fitness, Cardiac Rehabilitation, Exercise Physiology, Industrial Fitness, Sports Medicine, and Wellness. Inquiries: LaCrosse Exercise Program-Workshop Unit, Mitchell Hall, UW-L, LaCrosse, Wis 54601 (ph 608/785-8686).

OCTOBER 17-18, 1981: *Therapeutics III—1981,* Madison. Sponsored by University of Wisconsin, School of Medicine, Dept of Medicine; and University of Wisconsin, Extension, Continuing Medical Education. AMA Category I; University of Wisconsin continuing education units; AOA and Family Practice credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706; ph 608/263-2856.

OCTOBER 22-24, 1981: *Radiology and Breast Cancer,* Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Radiology. AMA Category 1, University of Wisconsin continuing education units, ACR pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706; ph 608/263-2856.

OCTOBER 30-31, 1981: *Osteoporosis,* Madison. University of Wisconsin, Extension, Dept of Continuing Education; and University of Wisconsin, School of Medicine, Department of Preventive Medicine. AMA Category I; AOA and family practice credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706; ph 608/263-2856.

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1981-1982

Wisconsin Society of Anesthesiologists, Sept 18-20, 1981, Lake Lawn, Lake Delavan

Wisconsin Dermatological Society, Oct 24, 1981, Froedtert Memorial Lutheran Hospital, Milwaukee; and Feb 27, 1982, University of Wisconsin Center for Health Sciences, Madison

Wisconsin Neurosurgical Society, September 18-19, 1981, Madison

Wisconsin Society of Obstetrics & Gynecology, June 11-13, 1981, Telemark Lodge, Cable

Wisconsin Section, American College of Obstetricians & Gynecologists (District VI), Sept 9-12, 1981, Minneapolis, Minn

Wisconsin Society of Otolaryngology, Aug 29-30, 1981, Maxwelton Braes Resort, Baileys Harbor

Wisconsin Society of Pathologists, October 1981

Wisconsin Chapter, American Academy of Pediatrics, Sept 11-12, 1981, University of Wisconsin Clinical Science Center, Madison

Wisconsin Radiological Society, Oct 10, 1981, Concourse Hotel, Madison

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SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, May 13-15, 1982, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

NOVEMBER 13, 1981: Wisconsin Orthopaedic Society, Olympia Resort, Oconomowoc.

FEBRUARY 25-28, 1982: Wisconsin Psychiatric Association, Lake Lawn Lodge, Lake Delavan.

MIDWEST

SEPTEMBER 10-11, 1981: 41st Annual AMA Congress on Occupational Health/Central States Occupational Medical Association Fall Seminar. This two-day meeting will include practical clinical information on respiratory problems, pain clinics, cardiac problems and arthritis as they relate to the working population. It will be held at the Pfister Hotel in Milwaukee, Wis. Fee: $60 physicians, $40 allied health professionals. Info: Dept of Environmental Public and Occupational Health, American Medical Association, 535 N Dearborn St, Chicago, IL 60610.

SEPTEMBER 17-19, 1981 (Minnesota): *Current Clinical Cardiology seminar,* at United Hospitals of Saint Paul. See details in box elsewhere in this section.

SEPTEMBER 18-19, 1981 (Chicago, IL): AMA Hospital Medical Staff Leadership Seminar, Drake Hotel, Chicago. Info: Dept of Hospitals & Health Facilities, AMA, 535 N Dearborn St, Chicago, IL 60610; ph 312/751-6656. (See ad elsewhere in this section.)

MIDWEST Regional CME meetings American College of Physicians

SEPTEMBER 10-12, 1981 (Ohio): Daytonian Inn, Dayton, OH. Info: Richard G Farmer, MD, FACP, Cleveland Clinic, 9500 Euclid, Cleveland, OH 44106.

SEPTEMBER 11-12, 1981 (South Dakota): Alex Johnson Hotel, Rapid City. Info: Reuben J A Bareis, MD, FACP, PO Box 3115, 2800 Jackson Blvd, Rapid City, SD 57701.

SEPTEMBER 11-12, 1981 (Wisconsin): LaCrosse. Info: Charles L Junkerman, MD, FACP, 831 N 66th St, Wauwatosa, WI 53213.

SEPTEMBER 19-20, 1981 (Illinois): Drake Hotel, Chicago. Info: Rolf M Gunnar, MD, FACP, Loyola University Medical Center, 2160 S First Ave, Maywood, IL 60153.

OCTOBER 8-11, 1981 (Michigan): Boyne Highlands, Harbor Springs. Info: Boy Frame, MD, FACP, 543 Lakepointe, Grosse Pointe Park, MI 48230.

OCTOBER 15-17, 1981 (Missouri): Almedea Plaza Hotel, Kansas City. Info: Davis M Kipnis MD, FACP, Dept of Medicine, Washington University School of Medicine, 660 S Euclid, St Louis, MO 63110.

OCTOBER 1981 (Minnesota): Rochester. Info: John A Spittell Jr, MD, FACP, Mayo Clinic, 200 First St SW, Rochester, MN 55901.

NOVEMBER 20, 1981 (Indiana): Hilton Hotel, Indianapolis. Info: Walter J Daly, MD, FACP, Indiana University Medical Center, Emerson Hall, Room 317, 1100 W Michigan St, Indianapolis, IN 46223.

OTHERS

OCTOBER 17-21, 1981 (Louisiana): Annual Meeting, American Society of Anesthesiologists, New Orleans. Info: ASA, 515 Busse Highway, Park Ridge, Illinois 60068 (ph 312/825-5586).

OCTOBER 23-25, 1981 (Florida): *Medical staff issues and the practicing physician* seminar by JCAH, at Innisbrook, Tarpon Springs, FL. Registrar: Charlotte Wells, Florida Hospital Association, PO Box 6905, Orlando, FL 32853 (phone: 305/841-6230).

OCTOBER 31-NOVEMBER 5, 1981 (New Orleans, La): American Academy of Pediatrics 1981 Annual Meeting, New Orleans, La. Info: American Academy of Pediatrics, PO Box 1034, 1801 Hinman Ave, Evanston, Ill 60204.

NOVEMBER 6-9, 1981 (Nevada): *Medical staff issues and the practicing physician* seminar by JCAH, at Las Vegas, Nev. Registrar: Julie Efaw, Joint Commission on Accreditation of Hospitals, 875 N Michigan Ave, Chicago, IL 60611 (phone: 312/642-6061).

DECEMBER 8-10, 1981 (Florida): *American Cancer Society National Conference-Gastrointestinal Cancer-1981,* Fontainebleau Hilton Hotel, Miami Beach, Fl. Approved 13 credit hours Category I of AMA-PRA and AAFP. Info: Nicholas G Bottiglieri, MD, American Cancer Society, National Conference-Gastrointestinal Cancer-1981, 777 Third Ave, New York, NY 10017.

First Annual Jesse E Edwards, MD Lectureship highlights a seminar—

Current Clinical Cardiology

September 17-18-19, 1981—St Paul, Minn

Intended for Family Physicians, Internists, and Cardiologists. Cosponsored by United Hospitals of St Paul and the American Heart Association—Minnesota Affiliate, Inc

W Proctor Harvey, MD, Georgetown University, will give the Edwards Lecture, and clinicians from around the country will update physicians in four general areas: adult noninvasive cardiology, pediatric cardiology, interventional cardiology, and medical therapy of cardiovascular disease.

Course is certified for 17 credit hours in Category 1 of the Physician's Recognition Award of the AMA. Accreditation from additional accrediting agencies applied for.

Registration fee: $45 includes luncheons, reception and course materials. Further info:

Medical Staff Office, United Hospitals
333 N Smith Ave, St Paul, MN 55102
Phone: 612/298-8558 p8/81

SNOWMASS/VAIL "MEP" SKI SEMINAR

On Management Enrichment for the Health Professional

Ski Snowmass, Colorado the week of December 19, 1981 or the week of March 20, 1982; or ski Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Seminars comply with IRS rules to make trip expenses deductible for doctor and spouse. For brochure and lodging information contact: MEP, An Education Corporation, 906 Cooper Ave, Glenwood Springs, Colorado 81601; or call 800/525-3402. 6-9/81

FEBRUARY 27-MARCH 6, 1982 (Capitiva Island, Florida): 20 hours, Category 1/prescribed. For primary care physicians. Contact Minnesota Medical Assn, Suite 400, Health Association Ctr, 2221 University Ave, SE, Minneapolis, MN 55414, ph 612/378-1875. 8/81

MAY 16-20, 1982 (Brazil): *The Fifth International Symposium on the Prevention and Detection of Cancer, San Paulo, Brazil.* Sponsored by Fundacao "Centro de Pesquisda de Oncologia" and The International Society for Preventive Oncology; Info: Medical Congress Coordinators Department, 1212 Avenue of the Americas, New York, NY 10036; ph 212/840-0110. g8-12/81; 1-4/82

AMA

DECEMBER 6-9, 1981: Interim AMA House of Delegates, Las Vegas, Nev.

FEBRUARY 25-28, 1982: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl. ■

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HEALTH CARE COST CONTAINMENT SEMINAR

October 12-14, 1982—Palm Springs, California—Spa Hotel

First such seminar to be held by the International Foundation of Employee Benefit Plans, John L Watts, president.

Purpose is to give representatives of employee hospital-medical benefit plans information and insight needed to plan and implement effective cost containment programs.

An overview of the US health delivery system will kick off the three-day program, followed by presentations on health care costs and the role of health planning; the position of the Reagan Administration; cost containment through plan design; cost containment through administration; cost savings and benefits of alcoholism, drug, and other special programs, and the future of benefit plans.

Registration fee for Foundation members and nonmembers alike will be $360 each.

More information may be obtained by writing or telephoning the International Foundation of Employee Benefit Plans, PO Box 69, Brookfield, Wisconsin 53005. Telephone 414/786-6700.

Ninth Annual Illinois Congress on Continuing Medical Education

September 11-12, 1981

Friday, Sept 11, 7:45 pm to Saturday, Sept 12, 5:00 pm

Oak Brook Hyatt Hotel, Spring & Harger Roads

Oak Brook, Illinois

How Physicians Learn: Effective Methods in CME

This year's Congress, sponsored by the Illinois Council on Continuing Medical Education is the second of a four-year program cycle presenting all the fundamentals of CME planning. The 1981 program focuses on effective learning methods as well as skill in selecting methods likely to achieve specific CME Program Goals and Learning Objectives.

Highlighting this year's program will be *Howard S Barrows, MD,* Associate Dean/Education Affairs, Southern Illinois University School of Medicine, known internationally for his work in *problem-solving* and *simulations* in medical education.

Most of the Congress consists of small-group workshops, such as: Matching Methods to Needs, Teaching with Technology, Self-Directed Learning Techniques, Do's and Don'ts of Didactics, Medical Audit as a Learning Method. There also will be a special workshop for non-physician CME Coordinators.

For additional information, write or call the **Illinois Council/CME, 55 E Monroe, Suite 3510, Chicago, Illinois 60603 (ph 312/236-6110).**

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

MEDICAL EXAMINING BOARD ACTION. The State Medical Examining Board has revoked the medical license of Joseph E Swanton MD, Mountain City, Tennessee because he violated Wisconsin law when his Tennessee license was suspended for two years and he was subsequently placed on probation. The State of Tennessee took the disciplinary action due to Swanton's abuse of alcohol and drugs. The Board has accepted the voluntary surrender of the license held by Frank R Schulkin MD of San Francisco, California. Schulkin violated Wisconsin law when his California medical license was revoked and when he was subsequently placed on probation.

SMS PRESIDENT-ELECT TESTIFIES ON FTC ACTIVITIES REGARDING PEER REVIEW. "As a result of Federal Trade Commission (FTC) constraints on medical peer review activities, individuals who might be guilty of providing questionable medical care escape the criticism and corrective action of their peers," SMS President-elect Gerald C Kempthorne MD, Spring Green, told a US Senate subcommittee last month. Doctor Kempthorne testified at an oversight hearing July 15 before the Subcommittee on the Consumer of the US Senate Commerce, Science, and Transportation Committee on the FTC's activities concerning doctors, lawyers, and other professional groups. The complete text of Doctor Kempthorne's testimony appears elsewhere in this issue.

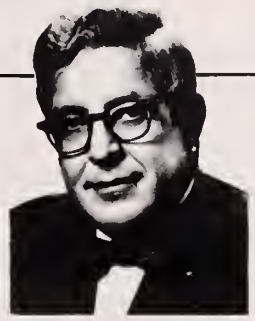
PEDIATRIC CLAIMS TO BE ADJUSTED, PAYMENT METHODOLOGY REVISED. Physicians who received reduced payments for pediatric services under the Wisconsin Medical Assistance Program after Feb 1, 1981 should resubmit the affected claims to EDS Federal Corporation for adjustment, State Department of Health and Social Services says. Medicaid Director Martin Preizler said the erroneous payments occurred because: (1) Medicare data used to develop pediatric profiles did not accurately reflect the pediatric community's fee structure; and (2) due to the fact that pediatricians had no existing Medicare profiles, all pediatricians were categorized as "newly in practice." Thus payment was limited to the 50th percentile of charges rather than the 75th percentile which is applied to established physicians. DHSS has now instructed EDS to use the 75th percentile as the upper bound on payment for all pediatricians and replace the inappropriate Medicare data derived from Medicaid charges. As a result, pediatricians will now receive the lower of the locality's Medicaid derived 75th percentile as the locality's coefficient times the procedure's relative value.

REMINDER ON NEWBORN TESTING FOR GONOCOCCAL OPHTHALMIA. A reminder to physicians: Wisconsin law [Sec. H 45.25 (4) Wis. Adm. Code] requires that you administer either silver nitrate, tetracycline, or erythromycin to newborn children as soon as possible, but not later than one hour after birth for the prevention of gonococcal ophthalmia. The law does not provide for exemptions from this requirement under any circumstances.

WISCONSIN PSROs RANKED HIGH, LOW. Wisconsin's Professional Standards Review Organizations (PSROs) ranked high and low in a national ranking of performance levels conducted by the US Dept of Health and Human Services (HHS). HHS conducted the evaluation to (1) identify PSROs that failed to meet minimum program performance requirements, and (2) develop a performance-based ranking to be used if budget support for the PSRO program is reduced by Congress. The Wisconsin Professional Review Organization (WisPRO) received 2037 points out of a possible 2350 ranking 13th out of the nation's 182 PSROs. The Foundation for Medical Care Evaluation in Southeastern Wisconsin (FMCE) was ranked 124th.

POSTAL RATE CHANGES TO AFFECT MEDICAL JOURNALS. Between now and next March, physicians will be asked to complete and return request or subscription cards if they wish to continue receiving complimentary medical journals published by the American Medical Association. New postal rate changes, scheduled to take effect March 22, 1982, will merge controlled circulation rates with regular second class postage rates. The net effect of this action will require these journals to have at least 50% of their total circulation on a request and/or subscription basis or pay the higher first or third class rates. The AMA encourages physicians to promptly complete the request cards for each complimentary journal he/she wishes to receive after the March 22 deadline. ■

Commentary



Holistic Medicine . . . J D Kabler, MD, Madison, Wisconsin

HOLISTIC MEDICINE is a controversial contemporary concept defined by its promoters as a "system of health care which emphasizes personal responsibility, and fosters a cooperative relationship among all those involved, leading toward optimal attunement of body, mind, emotions and spirit." Holistic Medicine, it is claimed, "encompasses all safe modalities of diagnosis and treatment including drugs and surgery, the necessity of looking at the whole person, including analysis of physical, nutritional, environmental, emotional, spiritual and life style values."

Given such an appealing description, why is Holistic Medicine so controversial? In what way does Holistic Medicine, as it is practiced, differ from the health care provided by competent, regular primary care physicians now?

Holistic Medicine is controversial because it has uncritically incorporated alien philosophies and unproved practices such as astrology, Oriental mysticism, and ancient religions as well as prescientific notions and nostrums into its offerings. Holistic Medicine is controversial because, although the movement has attracted some physicians and other qualified professionals, many practitioners in this field lack the customary educational, training, and experience backgrounds normally found among others who treat the sick.

As it is in fact practiced by its adherents, how does Holistic Medicine differ from care normally provided by primary care physicians? Medical students learn and regular primary care physicians do put into practice considerations of physical, mental, nutritional, educational, occupational, environmental, and many other factors as they affect the well-being of their patients. Ideally, Holistic Medicine practitioners should do no less and, indeed, commonly claim to add something more. Unfortunately, the "something more" is too often a revival of old, discarded systems of healing (*eg,* homeopathy and naturopathy), discredited doctrines such as iridology, treatments based on imaginary ideas of body structure and function including auriculopathy and reflexology, and even on imagination itself, as in so-called visualization therapy.

What are some of these "opathies" and "ologies" that contribute so much controversy to Holistic Medicine? Homeopathy, for example, teaches that a remedy cures a disease only if it produces symptoms of the disease in a healthy person. Thus, laxatives should be given to treat diarrhea! Another homeopathic principle is that medicines become stronger the more they are diluted by water so that one part medicine in a billion parts of water may be prescribed by homeopaths.

The basic premise of iridology or iris diagnosis is that each organ of the body has a corresponding location in the iris or colored portion of the eye; a part of the left iris for the left kidney and left arm, and so forth. The trouble with this notion is that it doesn't work. In a 1979 study practitioners of iridology who examined the eyes of persons with and without kidney disease failed to identify those who had disease from those who did not any better than by chance. Flipping coins would have worked as well.

Reflexologists claim that massage of a foot will improve the function of organs on that side of the body. In their view if you have trouble with your right sinuses, you should massage your right little toe!

If these measures were all harmless, perhaps it wouldn't matter. But some herbs are poisons, ineffective methods can delay use of valid ones, and personal resources and valuable time can be wasted.

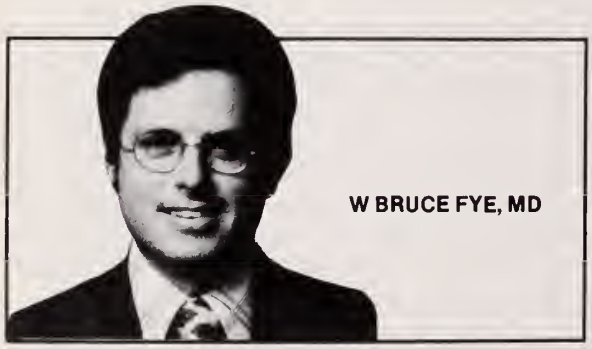
Until its practitioners can provide credible evidence—beyond just assertion, anecdote, and superstition—that their methods are effective and beneficial, Holistic Medicine will remain encased in controversy. ■

Medical history in Wisconsin . . . W Bruce Fye, MD, Marshfield, Wisconsin

A RECENT SYMPOSIUM "Wisconsin Medicine: Historical Perspectives" held at the Marshfield Clinic demonstrated the vitality of medical history in this state. Historical surveys of topics including medical societies in Wisconsin, sectarian medicine, public health in Milwaukee, and rural health care in Wisconsin were presented to an audience of nearly 50 individuals. The diversity of the participating faculty and the audience reflected the growing role nonphysicians are playing in the history of medicine. In-

dividuals with training in history, sociology, and specialty fields within history such as the history of science and medicine are joining ranks with the amateur or part-time physician-historian to enlarge the sphere of study and influence of the history of medicine.[1]

Graduates of the University of Wisconsin Medical School are familiar with the William Snow Miller lectures and the heritage of the physician-historian begun in this state by Miller and perpetuated by his pupils. Over the last three decades the History of Medicine Department of the University of Wisconsin-Madison has grown to become one of the strongest in the nation. This Department serves as the institutional and intellectual center of medical historical activities in our state. A strong faculty is complemented by a superb library (William S Middleton Memorial Medical Library) with rich collections in the history of medicine. Occasional lectures and seminars are held and are open to physicians.



W BRUCE FYE, MD

Another opportunity for physician involvement in medical history in the State of Wisconsin is through the Aesculapian Society, the historical arm of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin. The Society is responsible for the operation and promotion of the Fort Crawford Medical Museum in Prairie du Chien: The Museum (open from May 1 through October 31) is well worth a visit if you are planning a trip to Southwestern Wisconsin. Several pockets of interest in the history of medicine exist throughout the state. Medical history clubs exist at the Gundersen Clinic in La Crosse, the Marshfield Clinic, and in Milwaukee. Doubtless, there is potential for forming similar clubs in other areas throughout the state.

On a national level the American Association for the History of Medicine holds its annual meeting in May. The 1983 meeting will be in Minneapolis. Membership in this organization includes a subscription to the *Bulletin of the History of Medicine,* a scholarly publication devoted to the field. Our neighboring state, Minnesota, is fortunate in having a strong Department of the History of Medicine in its University. *The Journal of the History of Medicine and Allied Sciences* is edited in that department. An organization recently formed to bring together individuals interested in the history of medicine from the Upper Midwest is the "North of 40 Medical History Society" which meets annually.

Not only can the history of medicine provide the practicing physician with a welcome change of pace from what is often a very hectic life but also it provides an excellent opportunity for original research into a wide variety of topics in the history of our profession. The literature of medical history is large; however, numerous tools exist to introduce the novice physician-historian to it.[2]

An ideal opportunity exists within Wisconsin for the furtherance of medical history. For the practicing physician it may be both an enjoyable avocation and a scholarly pursuit. Physicians interested in the history of medicine are encouraged to participate in the activities of the various groups detailed below. Further information on any of them may be obtained by writing directly to the organizations or to me.

①Aesculapain Society. State Medical Society of Wisconsin. PO Box 1109. Madison, Wisconsin 53701. Telephone 1-608-257-6781 or toll-free in Wisconsin 1-800-362-9080. Membership $10.00 annually.

②American Association for the History of Medicine. Robert P Hudson, MD, Secretary-Treasurer. Department of the History of Medicine. Kansas University Medical Center. Kansas City, Kansas 66103. Membership $18.00 annually which includes a subscription to the *Bulletin of the History of Medicine.*

③"North of 40 Medical History Society."

④Department of the History of Medicine, University of Wisconsin-Madison (seminars and lectures). Departmental Secretary. Department of the History of Medicine. University of Wisconsin Center for Health Sciences. 1305 Linden Avenue. Madison, Wisconsin 53706. Telephone 1-608-262-1460.

⑤Marshfield Medical History Club. W Bruce Fye, MD Marshfield Clinic. Marshfield, Wisconsin 54449. Telephone 1-715-387-5301.

REFERENCES

1. Numbers RL, Leavitt JW: *Wisconsin Medicine.* Madison, University of Wisconsin Press, 1981.
2. Fye WB: The literature and history of internal medicine; an annotated bibliography. *Ann Int Med* 87:123-128, 1977. ■

Doctor Fye is from the Department of Cardiology, Marshfield Clinic, Marshfield, Wisconsin 54449. Copyright 1981 by the State Medical Society of Wisconsin.

Isoproterenol overdose

Peter Kosolcharoen, MD; Ashvin K Patel, MBChB, M Med (EA), FACC; and James H Thomsen, MD
Madison, Wisconsin

ABSTRACT. *A large dose of intravenous isoproterenol (2.5 mg) was given inadvertently to a patient with coronary artery disease. The patient developed marked hypotension, palpitation, and angina which responded to prompt administration of intravenous propranolol and fluid therapy. Accidental isoproterenol toxicity can be life-threatening and judicious use of intravenous β-adrenergic blocker may be life-saving.*

ISOPROTERENOL, a sympathomimetic agent with exclusive β-adrenergic activity, acts mainly on the smooth muscles and cardiovascular system. It is a potent bronchodilator and a cardiac stimulant that is useful in the treatment of atrial-ventricular heart block, cardiac standstill, and cardiogenic shock.[1] Serious cardiac complications may occur even with therapeutic dosages of isoproterenol.[2] Despite its deleterious effects, information on toxic dosage of the drug for humans is scanty. The present report describes a cardiac patient who was inadvertently given a massive dose of isoproterenol. He responded favorably to the administration of propranolol.

CASE REPORT. A 54-year-old white male with coronary artery disease was admitted to the William S Middleton Memorial Veterans Administration Hospital, for elective cardiac catheterization. Six years earlier, he had sustained an inferior wall myocardial infarction. Cardiac catheterization six months later showed hypokinetic anterolateral and akinetic postero-inferior segments of the left ventricle. The ejection fraction was 56% and a dominant right coronary artery was totally occluded near its origin. The distal segment was filled by collateral circulation from the left coronary artery. He was treated with isosorbide dinitrate, digoxin, and quinidine with satisfactory control of his angina and frequent ventricular premature contractions.

From the Cardiology Section, William S Middleton Memorial Veterans Hospital, and the Medical Service, University of Wisconsin Health Sciences Center, Madison, Wisconsin. This study supported in part by the Medical Research Service of the Veterans Administration. Doctor Kosolcharoen is an Assistant Professor, Doctor Patel an Associate Professor, and Doctor Thomsen an Associate Professor, University of Wisconsin Health Sciences Center. Reprint requests to: Peter Kosolcharoen, MD, Cardiology Section, Wm S Middleton Memorial Veterans Hospital, 2500 Overlook Terrace, Madison, Wis 53705 (phone: 608/256-1901). Copyright 1981 by the State Medical Society of Wisconsin.

Physical examination during the present admission revealed a well-developed male weighing 80 kg. His blood pressure was 110/70 mmHg and the pulse rate was 60 beats per minute. Cardiovascular examination revealed a left atrial contraction sound. Chest roentgenogram was normal. Electrocardiographic studies showed regular sinus rhythm at a rate of 60 beats per minute and an old inferior wall myocardial infarction.

During the routine preparation for cardiac catheterization, he became apprehensive and dizzy. Electrocardiographic studies showed a sinus bradycardia of 45 beats per minute and a systolic blood pressure of 65 mmHg by palpation. A vasovagal attack was diagnosed and successfully treated with 0.8 mg atropine intravenously. The heart rate increased to 72 beats per minute, the systolic blood pressure to 80 mmHg, and dizziness cleared. Because of persistent anxiety, 2.5 mg of intravenous diazepam (Valium®) was prescribed for the patient. Within 30 seconds after the drug infusion, his heart rate suddenly increased to 190 beats per minute and the blood pressure could not be obtained. He complained of palpitation, faintness, and angina. Despite marked hypotension, his skin was warm. A supraventricular tachyarrhythmia was diagnosed. Attempted cardioversions by carotid sinus pressure and 50 watt-second synchronous DC countershock were unsuccessful. Careful reevaluation showed the rhythm to be a sinus tachycardia. Further investigation revealed that the patient had received 2.5 mg isoproterenol intravenously instead of diazepam. One mg of propranolol was given intravenously and 5% dextrose water was rapidly infused. Within two minutes, heart rate was reduced to 90 beats per minute, the systolic blood pressure rose to 90 mmHg, and his symptoms improved. Subsequent observations in the coronary care unit showed no complications. A standard 12-lead electrocardiogram demonstrated no evidence of new ischemia or myocardial infarction. The patient recovered uneventfully.

DISCUSSION. The toxic effects of isoproterenol are well-documented in animal studies, including reduction in coronary blood flow,[3] myocardial

EDITORIAL COMMENT: ***The problem of isoproterenol toxicity has a broader implication than suggested by this single case report, inasmuch as other cardiac complications can be found "even with therapeutic dosages of isoproterenol."***

necrosis similar to myocardial infarction from coronary artery disease,[4] and death in the failing myocardium.[5] In the 1960s, an increase in mortality from bronchial asthma in England and Wales was attributed to aerosol bronchodilators.[6] Aelony *et al*[7] reported a patient who developed acute myocardial infarction after inhaling 675 mg of aerosolized isoproterenol in two and one-half days. This dosage was 18 times higher than the maximum dose usually prescribed for the treatment of bronchial asthma. In eight cases reviewed by Winsor and Berger,[2] cardiac toxicity occurred despite therapeutic dosage of isoproterenol. Two patients had acute myocardial infarctions, one of whom died, and the other had transient myocardial ischemia aborted by discontinuation of isoproterenol and administration of nitroglycerin. However, Matthews[8] treated a patient with complete heart block by intravenous isoproterenol at a dose as high as 154 μg per minute without cardiac or systemic toxicity.

In the case presented here the patient was accidentally given 2.5 mg of intravenous isoproterenol which was 14 times higher than the recommended dosage for treatment of cardiac standstill in adults. Massive vasodilatation caused a striking fall of blood pressure which was not compensated by the marked rise in inotropic and chronotropic activity of the myocardium. Angina was probably due to extreme stress, hypotension with decreased coronary perfusion, and increased myocardial oxygen consumption in the presence of the underlying ischemic heart disease. Although the half-life of isoproterenol given intravenously is about one minute, myocardial injury and even death could have occurred in this patient if not for quick recognition of the problem and prompt administration of propranolol and fluid therapy.

A lethal dose of isoproterenol in humans has not been firmly established. In small, rapid intravenous injections, there are significant individual differences in the β-adrenoreceptor's sensitivity.[9] To our knowledge this communication reports the highest intravenous dose actually given to a human being.

Accidental administration of a large quantity of isoproterenol can also happen during cardiopulmonary resuscitation and mechanical failure of continuous intravenous infusion apparatus. Since patients with cardiac disease are the likely candidates for intravenous isoproterenol therapy, morbidity and mortality will be enhanced in the presence of toxicity. Immediate recognition of the problem, discontinuation of the drug, followed by prompt resuscitation with intravenous β-adrenergic antagonist and fluid therapy may be life-saving.

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ABSTRACT

Femorotibial bypass grafts with sequential technique

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Arch Surg 116: 709-714 (May) 1981. (Read before the 88th annual meeting of the Western Surgical Association, Salt Lake City, Nov 19, 1980.)

Twenty-three patients (mean age, 71 years) have undergone femorotibial bypass grafting with a sequential side-to-side popliteal anastomosis since 1975, 96% because of threatened limb loss. Twenty-one grafts were of autogenous saphenous vein and two were composites of prosthesis and vein. Ankle-brachial indices increased from 0.40 ± 0.27 to 0.84 ± 0.36. Intraoperative flow measurements showed a 40% to 75% augmentation in flow with the sequential anastomosis. Patients who required amputation in the early postoperative period because of graft failure failed to show improvement in ankle indices and did not manifest healing of their ischemic ulcerations. Nineteen of 23 limbs (83%) were salvaged by operation. Follow-up ranged from two to 50 months (mean, 23 months). Graft patency calculated by the life-table method was 74% at one year, 68% at two years, and 62% at four years. ■

Cor triatriatum

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COR TRIATRIATUM is a rare form of congenital heart disease in which the left atrium is divided into two chambers by a fibromuscular diaphragm.[1] The upper chamber contains the pulmonary veins, while the lower chamber is in reality the true left atrium. It has a typical left atrial appendage and opens into the left ventricle via a mitral valve. One or more fenestrations are present in the obstructing membrane, allowing a limited amount of pulmonary venous return to enter the true left atrium and left ventricle. The physiologic picture is that of obstruction of pulmonary venous return, and the differential anatomic diagnosis includes mitral valve stenosis, supravalvar mitral ring, and stenosis of the pulmonary veins. It is estimated that the frequency of occurrence of cor triatriatum is 0.1 percent of all congenital cardiac malformations.[2]

We have recently cared for a child with cor triatriatum who underwent successful surgical repair. In addition to the manifestation of certain typical clinical and laboratory findings, postoperative support in this patient involved the use of tolazoline (Priscoline®) to lower pulmonary artery resistance. This was felt to be life-saving. We review this case to acquaint physicians with the diagnosis and management of this anomaly.

CASE REPORT. The patient was a 14-month-old male who had gained weight poorly, was irritable and in whom a heart murmur had been recently noted.

On physical examination the weight was below the third percentile. The child was pale but without cyanosis. Mild tachypnea with substernal retractions was present. The liver was palpable 3 cm below the right costal margin. The precordium was full with a hyperactive left sternal border. A grade II/VI long systolic murmur was heard along the sternal border and this was followed by a grade II/VI diastolic murmur at the apex.

The chest x-ray film revealed the presence of cardiomegaly with prominence of the pulmonary arteries and pulmonary venous congestion (Fig 1). The electrocardiographic studies showed right axis deviation with marked right ventricular hypertrophy. The two-dimensional echocardiogram revealed the presence of a supravalvar (mitral) membrane in the long-axis, sub-xyphoid, and apical views.

FIGURE 1—*Preoperative chest x-ray film. Note cardiomegaly and prominent right and left pulmonary artery.*

Cardiac catheterization failed to demonstrate any intracardiac shunting. There was suprasystemic pressure in the pulmonary artery. A cineangiogram with injection into the main pulmonary artery and follow through views of the left atrium revealed the presence of a membrane dividing the atrium into two chambers—with the entrance of the pulmonary veins superior to the membrane (Fig 2).

The patient underwent cardiac surgery using cardiopulmonary bypass and surface cooling. When the left atrium was opened, a fibrous membrane was noted dividing the left atrium into two chambers. A 5-6 mm opening in this membrane allowed pulmonary venous return from the upper chamber to enter the lower chamber. The left atrial appendage entered the lower chamber. There was a 3x3 mm patent foramen ovale in the atrial septum between the lower left atrial chamber and the right atrium. This membrane was successfully excised.

After rewarming the child would not come off cardiopulmonary bypass. With each attempt system-

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FIGURE 2—*Cineangiogram. The balloon catheter is in the pulmonary artery. Dye has filled both portions of the left atrium. Note the upper portion of the left atrium (large black arrow), lower portion of the left atrium (small black arrow), and the dividing membrane (three white arrows).*

ic blood pressure fell in spite of the use of high doses of dopamine (Intropin®). It was noted at this time that pulmonary artery pressure was still at systemic levels and it was felt that there was persistent elevation of pulmonary vascular resistance. Tolazoline was added to the pharmacologic regimen and infused through a catheter inserted into the pulmonary artery. This lowered pulmonary artery pressure; the child came off bypass and was returned to the intensive care unit. He was gradually weaned from the tolazoline and was discharged on the 10th postoperative day.

COMMENT. Van Praagh et al[3] studied 13 postmortem cases of cor triatriatum. They felt that cor triatriatum develops because the common pulmonary vein is entrapped by tissue of the right horn of the sinus venosus during the fifth embryonic week. As a result, the common pulmonary vein is not incorporated into the true left atrium.

While clinical findings may suggest obstruction of pulmonary veins, more detailed anatomic diagnosis is dependent on sophisticated studies. Recently the echocardiogram has been of help, especially the two-dimensional technique. Moodie et al[4] described typical echocardiographic findings in this lesion. There is a structure behind the mitral valve (membrane) which moves anteriorly during atrial systole. In addition, evidence for pulmonary artery hypertension and right ventricular enlargement is noted. It is difficult to distinguish cor triatriatum from a supravalvar mitral membrane by echocardiogram.[5] Ultimately cardiac catheterization with cineangiography is required for a definitive diagnosis.

Other cardiac anomalies may be associated with cor triatriatum. These include ventricular septal defects, coarctation of the aorta and complete atrioventricular canal.[6] The association of these other lesions often makes it impossible to be certain about a preoperative diagnosis, even with catheterization.

The long-term result of chronic pulmonary arterial and venous hypertension due to cor triatriatum is the development of pulmonary vascular obstructive disease which is irreversible.[7] Following resection of the obstructing membrane in our patient, pulmonary artery pressure remained elevated and the patient could not be removed from cardiopulmonary bypass. The use of tolazoline, a potent pulmonary and systemic vasodilator, was life-saving. This drug has been used in patients with primary pulmonary artery hypertension with mixed results. In our patient, however, it lowered pulmonary vascular resistance sufficiently to allow the heart to function without mechanical support. A lung biopsy taken at surgery revealed only grade II Heath-Edwards changes. These are believed to be reversible. We expect that this patient will continue to do well.

SUMMARY. A case of cor triatriatum in a 14-month-old male child is presented. Clinical findings suggested the presence of pulmonary venous obstruction; the echocardiogram supported the diagnosis of cor triatriatum and the cardiac catheterization study confirmed this diagnosis. Surgical resection of the obstructing membrane was successful. Tolazoline was life-saving in the postoperative period.

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The condom as contraceptive and prophylactic—A reappraisal

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AT PRESENT THE only effective primary preventive measure against most sexually transmitted diseases is avoidance of contact with infected individuals. Sexual abstinence and mutual strictly one-partner relationships are the only completely reliable methods of avoiding contact with persons infected with sexually transmitted diseases. For individuals who have multiple sexual partners or whose sexual partner has multiple sexual partners, there is no certainty of avoiding sexually transmitted infections, but several measures can reduce the risk substantially. The first measure is to assess the relative risk of the prospective partner to exposure to sexually transmitted diseases. Prostitutes and other promiscuous persons, including promiscuous homosexuals, are high-risk partners, while nonpromiscuous persons generally are low-risk partners. The second measure is to inspect carefully the external genitalia of the partner prior to sexual contact for any evidence of disease, such as vesicles, erosions, ulcers, inflammation, or abnormal discharge. If orogenital contact is anticipated, the lips and oral cavity should also be inspected. The third measure is to use condoms regularly.

Use of condoms and perhaps the use of certain spermicidal chemicals somewhat reduces the likelihood of transmitting diseases through sexual contact. Condoms serve both as a contraceptive and as a prophylactic, are readily available without prescription, are inexpensive, require no prior planning, and are easy to use.[1] An ironic indication of health values in the United States today is the fact that cigarettes, which are known to cause disease, are prominently advertised in popular magazines, while condoms, which prevent disease and unwanted pregnancies, are not considered suitable for such advertisements.[2] Regular use of condoms has been shown to reduce the incidence of gonococcal infections quite significantly[3] and to reduce the incidence of genital herpes infections and syphilis by more than one half.[4] Several spermicidal chemical contraceptives have been shown to have antiviral and antibacterial activity *in vitro*.[5,6] What clinical significance the spermicidal chemical contraceptives may have in reducing sexually transmitted infections remains to be clarified.

The use of condoms regularly for contraception is at present very low in the United States, being used by only nine percent of couples, in contrast to Sweden and the United Kingdom, where 35 to 40 percent of couples use condoms regularly, and Japan, where 65 to 70 percent of couples use condoms regularly.[7] Condom use in the United States was much greater prior to the introduction of oral contraceptives and intrauterine devices. In the 1920s and 1930s, of the 71 percent of couples in the United States using contraceptive measures, 54 percent used condoms.[8] Several factors are thought to have contributed to very low condom use in the United States. First, condoms had been manufactured in the United States with thicker walls than in Europe and Japan, reducing tactile sensation. Recent improvements in technology, with improved latex and improved manufacturing processes, with dust-free drying rooms which almost eliminate the pinhole defects in condoms caused by dust particles settling on the drying latex, with semi-dry silicone lubricants, and with sealed foil packages which enhance shelf life, have permitted development of a much thinner-walled and more reliable product.[7]

Second, much of the information about the effectiveness of condoms in contraception which is available to the public in handbooks is based on studies in the 1930s, 1940s, and 1950s, when the total pregnancy rate per 100 woman years of condom use was 6 to 30 pregnancies. This was in part due to poor quality in condom manufacture. Prior to 1938 there were no quality control regulations for condoms in the United States, and the Food and Drug Administration estimated that 75 percent of the condoms produced in the United States were defective. In the 1940s and early 1950s, the tolerance for defective condoms was five percent. In 1957 the tolerance for defective condoms was lowered to one percent, and in 1968 it was lowered again to 0.25 percent. The contraceptive effectiveness of the modern condom regularly and properly used is about 0.8 to 2.6 failures per 100 woman years, compared with 1.5 to 3.0 failures per 100 woman years for intrauterine devices and 1 failure per 100 woman years for oral contraceptives. For poorly motivated or otherwise

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EDITORIAL COMMENT. *This topic has been particularly of interest to Doctor Shenefelt because of numerous young adults whom he sees with sexually transmitted diseases both as a dermatologist at University Health Service in Madison and as a physician at Blue Bus venereal disease clinic in Madison.*

ineffective users of contraception, the failure rate with either oral contraceptives or the condom can soar to levels of 11 to 28 failures per 100 woman years.[7]

Third, after the Comstock Act of 1873 declared contraceptives and information about contraception to be obscene and illegal, condoms were sold only as prophylactics against venereal disease, were often difficult to obtain, and were associated in the minds of many persons with prostitution and sexual promiscuity. This has had a negative impact on teenage use of condoms, since it does not fit in with the teenage fantasies of "good" sex being unplanned for, occurring spontaneously out of "true love," and hence often without any form of contraception or prophylaxis. In Sweden, in contrast, negative attitudes toward condoms have been changed by attractive and amusing advertising and youth-oriented marketing techniques that made condom-purchasing free of shame and even "trendy."[7]

In Wisconsin, advertising, exhibiting, or displaying condoms and other contraceptive articles for commercial purposes is still illegal under the archaic Wisconsin Statute 450.11. Vending machine sales of condoms and sales by anyone except a registered pharmacist or nurse or a licensed physician are also prohibited. The penalty for violating this law is not less than $100 nor more than $500 fine and/or imprisonment not to exceed six months. In 1974 comment was made in this journal that Wisconsin was the only state in the nation which still had this type of archaic contraceptive law.[9] Since then, Section 450.11 has been modified to eliminate the provision that made sale of contraceptive devices to unmarried persons illegal, but the ban on advertising, exhibiting, or displaying contraceptive articles for commercial purposes and the ban on vending machine sales of contraceptive devices remain in effect.

An opinion of the Wisconsin Attorney-General dated February 13, 1979 notes that subsections (2), (3), (4), and (5) of Section 450.11 relating to the sale and advertising of contraceptives are, based on recent United States Supreme Court decisions, a constitutionally infirm suppression of truthful information about a lawful activity and an unconstitutional restriction on the right of individuals to use contraceptives, having no relationship to the state interest and police power in protecting health.[10]

The usefulness of condoms as prophylaxis against venereal diseases has often been questioned, but a number of well-executed studies do show that consistent use of condoms does reduce the likelihood of acquiring gonorrhea by 35 to 45 percent, with a significant difference of $p < 0.001$ between correct users of condoms and erratic or nonusers of condoms.[3,4] Regular condom use reduces the likelihood of acquiring herpes simplex genitalis by 54 percent and that of acquiring syphilis by 62 percent. The likelihood of acquiring nonspecific urethritis, candidiasis, scabies, pediculosis pubis, and warts is unaffected by condom use.[4]

A campaign to promote condom use was begun in Sweden in 1970 because of a dramatically rising incidence of gonorrhea, particularly in the young adults and teenagers. As a result of vigorous promotional advertising in various media and open colorful displays of condoms in stores, sales of condoms increased by 50 percent in two years; and the incidence of gonorrhea, which had been climbing rapidly in the previous three years, was reduced by 20 percent. It should thus be kept in mind that the regular use of condoms by some individuals can have an effect on the incidence of venereal diseases such as gonorrhea, herpes genitalis, and syphilis even if they are not always used by all individuals having sexual intercourse. Even if the condom is only about 50 percent effective at preventing transmission of those diseases and if only about 25 percent of the population at high risk use it for every act of coitus, one can expect a dramatic decrease in the incidence of these venereal diseases within a relatively short period of time.[3]

Markedly decreased use of condoms in the United States after the introduction of oral contraceptives and intrauterine devices may well have been an important factor in the rapidly rising incidence of gonorrhea and herpes simplex genitalis infections in the past two decades. Recently, two articles have appeared in the American medical literature urging promotion of condom use among teenagers and young adults.[1,2] Perhaps the time is ripe for Americans to follow the lead of the Swedes in promoting condom use to decrease the incidence of sexually transmitted diseases.

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FIGURE 1(a)—*[L4-5 and S1; patient supine]; ie, without angulation [note: "4", "5", and "1" markers had been previously placed for Figure 1(b)].*

FIGURE 1(b)—*[L4-5 and L5-S1] tube angulation for joint space [L4-5 = 10°; L5-S1 = 20°].*

Computed tomography of the lumbar facet joints

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ABSTRACT. *Recent articles demonstrated the usefulness of computed tomography (CT) in evaluating the lumbar facet joints.*[1-4] *A technique is described to aid in positioning the scan-plane by using conventional C-arm fluoroscopy when the CT unit is not equipped with a lateral localizer.*

WE READ WITH GREAT interest the article of our colleagues Carrera et al about computed tomography (CT) in lumbar facet joints.[1] Unfortunately we were limited by the lack of a lateral localizer (Scout View®) image. To overcome this difficulty we have used the following procedure to achieve images of comparable diagnostic quality, rapidly and easily.

A patient is placed on a standard radiographic table in a supine position. Using conventional C-arm fluoroscopy and a felt-tip marker, the planes of the joint spaces with the necessary angulation are marked on the patient's abdomen. The CT exam, of the joints, can then be done with the necessary angulation which was determined by use of the C-arm. Although there is a minimal amount of radiation exposure, the accuracy of the CT study is enhanced and therefore repeat exams due to poor positioning are prevented.

Figure 1 demonstrates the difference in appearance when (a) patient is supine and (b) angulation is

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FIGURE 2(a)—*[L4-5; 10° angulation] scan of facets L4-L5.*

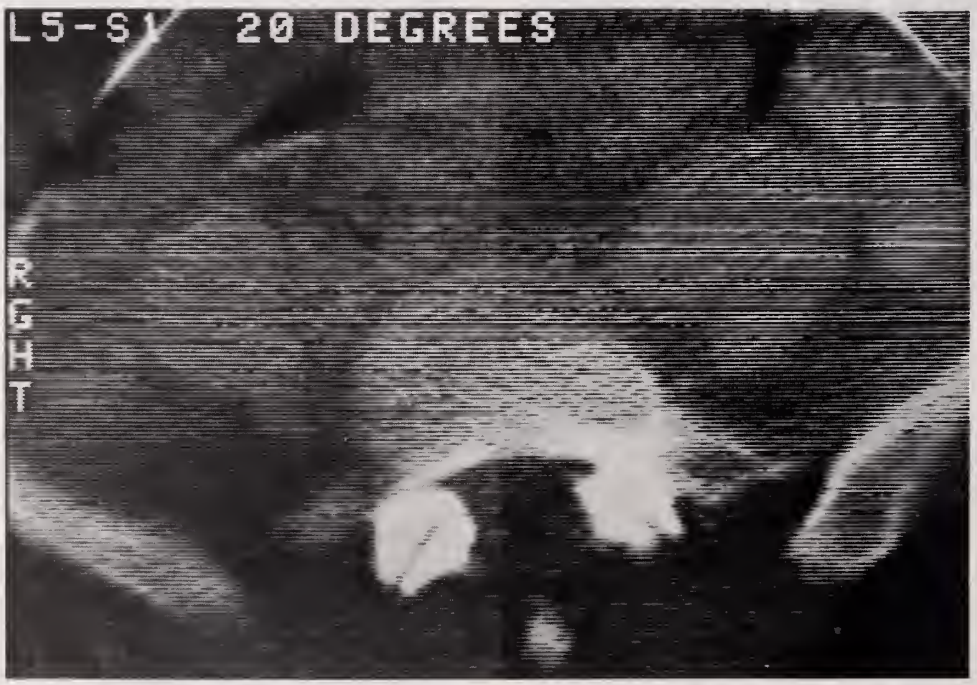

FIGURE 2(b)—*[L5-S1; 20° angulation] scan of facet L5-S1.*

proper to evaluate the joint space. Figure 2 (a) represents the scan at the level of L4-L5 when the proper angulation has been obtained and (b) proper angulation for L5-S1. Using this technique, studies comparable to our colleagues[1-4] can be obtained for diagnostic evaluation.

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Cesarean section in a rural community hospital Five-year survey of private obstetric practice

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THE CESAREAN SECTION rate in many private hospitals traditionally has been said to be substantially higher than the rate in public hospitals, and the rate in the United States continues to rise rapidly.[1-3]

However, the data come from institutions including attending physicians and residents, and no statistics have been reported of cesarean sections and related data, solely by a private practitioner.

Hence, the following statistics can be interesting because the obstetric cases cited are from a white ancestry population in a small rural community hospital where no residency program exists.

MATERIALS AND METHODS. These obstetric cases include those delivered vaginally and abdominally by the author from February 1975 through February 1980 at the Hartford Memorial Hospital, Hartford, Wisconsin.

During this period, no pregnant mother was transferred to other centers due to high risks, with the exception of one with pending prematures, delivered later vaginally at a big center and both survived. Every chart was reviewed. There were 822 deliveries and 78 cesarean sections. The indication for cesarean section was reviewed. Perinatal mortality, prematurity, and Apgar score constitute the studies for both cesarean and vaginal deliveries.

RESULTS. *Incidence and indications of cesarean sections*—There were 78 sections performed during the course of 822 deliveries, an incidence of 9.5 percent. The primary sections total 47, or 5.7 percent. Approximately 3.8 percent, or 31 repeat sections were done. Among 47 primary sections, 22, or 46.8 percent, were done for failure to progress. This group represents 2.7 percent of all deliveries.

Breech presentation was the indication for approximately one fourth of the indications for primary sections (11 cases, or 23.4 percent). Other indications were: fetal distress 4, abruptio placenta 3, prolapsed cord 2, placenta previa 1, and miscellaneous 4.

Of the 31 repeat cases, three required surgical intervention as an emergency procedure; two for premature rupture of the membranes and one for placenta previa. These deliveries were of preterm infants. One of them died shortly after birth.

The remaining 28 cases were delivered as elective sections. These deliveries included no preterm infants. Because of a diaphragmatic hernia, one newborn died after surgery.

Preterm delivery, perinatal death and poor Apgar score—The incidence of premature babies is 5.8 percent in all deliveries. The section group showed a doubly high incidence of prematurity, or 10.3 percent compared with a 5.4 percent prematurity in vaginal delivery.

The perinatal mortality rate and low Apgar score add up to higher incidence in cesarean sections. The figures amount to 64.1 and 3.8 percent in cesarean section, but 8.1 and 0.9 percent in vaginal delivery. The perinatal mortality in the entire series was 13.4 and the corrected perinatal mortality remains at 6.1 per 1000 deliveries. The perinatal deaths were caused by the following: congenital anomaly 4, prematurity 2, and intrauterine death 5.

Maternal mortality—There was no incidence of maternal mortality in either cesarean or vaginal deliveries.

DISCUSSION. The main purpose of this article is to show a comparison between statistics from large institutions and those reported by a private obstetrician.

A recent comprehensive study[4] showed that the recent increase in cesarean section rate is mainly attributable to four obstetric conditions: dystocia, breech, fetal distress, and previous cesarean section.

Dystocia. The most common single indication for cesarean section is dystocia or failure to progress, with an incidence of approximately 50 percent in primary section.[1-3] This indication also accounts for the largest part of the recent increase in cesarean section.[4]

Incidence of failure to progress in the series, or 2.7 percent of total deliveries is considered less than

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other reports.[2,3] This seems to be due to more midforceps operations in this study. During the study, 48 midforceps operations, or 5.8 percent of total deliveries, were accomplished.

Although most of the midforceps deliveries in the series were "elective" or "prophylactic" rotations, a few midforceps operations might have been substituted with cesarean sections by other performers. Neither perinatal mortality nor poor Apgar score was encountered. Any possible immediate or long-term morbidities of the babies have not been found. No maternal morbidity directly related to the midforceps operation was found in the series.

Breech. One of the controversial subjects in current obstetrics has been the management of breech presentation. The current cesarean section rate for breech presentation varies from one place to another, but in general, it is said to be 65-75 percent.[5] In the author's series, 19 of the 30 breech presentations or 63 percent, were delivered vaginally. Piper forceps were applied in 13 of the 19 cases. Except for two poor Apgar scores, the vaginally delivered infants showed no evidence of trauma to the brain, spinal cord, skeleton, or abdominal viscera. They were checked by pediatricians for at least one year of their lives and exhibited no neurological problems.

Summary on consensus development conference on childbirth by cesarean delivery

A NATIONAL INSTITUTES of Health Consensus Development Conference, held at NIH September 22-24, 1980, addressed the issue of childbirth by cesarean delivery. The conference was sponsored by the National Institute of Child Health and Human Development, in conjunction with the National Center for Health Care Technology and with the assistance of the Office for Medical Applications of Research, NIH.

After two days of considering expert presentations and audience comments, a 19-member task force, composed of specialists in a wide variety of medical and nonmedical disciplines, issued a consensus statement. This is a summary of that statement.

The nation's high cesarean section delivery rate may be lowered without impeding progress toward reducing maternal and infant mortality and morbidity. The trend of rising cesarean rates may be stopped or perhaps reversed while continuing to make improvements in maternal and fetal outcomes.

The United States cesarean rate tripled from 5.5 percent in 1970 to 15.2 in 1978, making cesarean section the tenth most common surgical procedure. Repeat cesarean deliveries are responsible for 30 percent of the overall rise in cesarean rates. More than 98 percent of the women in the United States undergo repeat cesareans for subsequent pregnancies.

Appropriate facilities, services, and staff should be available before attempting labor and vaginal delivery for women who have had a previous cesarean section. Hospitals should obtain informed consent before a trial of labor and develop guidelines for the management of those labors.

There should not be any changes in practice for elective repeat cesarean delivery by patients who have had a previous classical, inverted T-shaped, or low vertical incision, or for whom there is no documentation of the site and/or type of previous incision.

The diagnostic categories of dystocia, breech presentation, and fetal distress have also contributed to the increasing cesarean birth rate; and alternative management may reduce the need for cesarean.

Dystocia accounted for 30 percent of the overall rise in the cesarean delivery rate between 1970 and 1978. Physicians should try alternatives before considering cesareans during this prolonged labor and dysfunction, in the absence of fetal distress. These alternatives include patient rest, ambulation, sedation, or stimulation of labor by using oxytocin.

Breech presentation is responsible for about 15 percent of the rise in the cesarean rate. Vaginal delivery of the term birth is acceptable when the anticipated fetal weight is less than 8 pounds; pelvic dimensions and architecture are normal; hyperextension of the head is not present; and when delivery is conducted by a physician experienced in vaginal breech delivery.

Although fetal distress is diagnosed more frequently since the use of electronic fetal monitoring has become more common, it only occurs in about 1 percent of all births and accounts for 15 percent of the increase in cesarean rates.

There should be a liberalizing of hospital practices to allow fathers or surrogates to attend cesarean births at the request of the mother, and hospitals should permit healthy, cesarean-delivered babies to be with their parents immediately after birth.

For free copies of the cesarean delivery consensus development statement, contact the Office for Medical Applications of Research, National Intitutes of Health, Building 1, Room 216, Bethesda, Maryland 20205.

The NIH Consensus Development Program brings together biomedical investigators, practicing physicians, consumers, and others to carry out scientific evaluations of medical devices, procedures, and drugs. These technologies may be new or in general use. ■

Fetal Distress. In 1979 Banta and Thacker[6] reviewed electronic fetal monitoring and fetal scalp sampling extensively. They concluded that informed clinical judgment is still the best indication for a cesarean section in case of fetal distress. Incidence of fetal distress as a principal indication for cesarean section in the series, or 0.5 percent, is considered less than other reports.[2,3]

Previous cesarean section. The number of repeat sections has increased in proportion to the increasing number of primary cesarean sections. The author is one of the majority who follow the general dictum, "once a section, always a section." In order for vaginal delivery to make sense, there must be a greater danger in the repeat section than in the vaginal delivery. In this sense, iatrogenic prematurity by repeat section must be eliminated.

Ultrasonography became available in 1979 at Hartford Memorial Hospital. However, the decision on the timing of an operation by the author was based solely on clinical findings. No amniocentesis was done before elective repeat section in the present series. There were no preterm infants among the 29 elective sections.

The focus of obstetrics has been changed from an emphasis on mother and delivery to an emphasis on fetal outcome. A constantly decreasing number of physicians seem to be familiar with the use of forceps or the art of breech delivery.

SUMMARY. The author's "conservative" practice, rather than a "defensive" one resulted in a 5.7 percent primary cesarean rate and the corrected perinatal mortality rate of 6.1 per 1000 deliveries. The author believes that a successful decision on the type of delivery may be brought about only after a combination of adequate training and up-to-date experience along with a careful review of the outcome.

Furthermore, the author believes that the evaluation of these individual cesarean section and related data-statistics become more important and bear more weight than combined data from large institutions in order to assess standard obstetric practice.

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MEDICAL BRIEF

Bacterial infections in a skilled nursing facility

THE INCIDENCE OF bacterial infections occurring in 132 residents in a Veterans Administration hospital-based nursing home care unit (VA NHCU) was studied retrospectively over a one-year period.

There were 35 non-Foley catheter-related documented bacterial infections occurring in 23 residents. Of these 14 were pulmonary, 18 urinary and three of the integument. Of the 23 residents with indwelling urinary catheters, 47.8% became clinically symptomatic due to a urinary tract infection at least one time during the year. Thirty-six percent of these infections were due to Pseudomonas aeruginosa, and 48% were due to E. coli and Proteus mirabilis. Eighteen of 23 residents (78.3%) with Foley catheters had more than one predominant organism cultured from the urine during the year making the practice of monthly cultures not very useful in considering treatment. If one groups all urinary tract infections on the NHCU, the major pathogens were Pseudomonas (19.5%), E. coli (14.6%), Klebsiella (17.1%) and Proteus (17.1%). Documented pulmonary infections were due to streptococcal pneumonia (50.0%) and Hemophilus influenza (35.7%) predominantly. Our data suggest that the location of the institutional setting must be considered in caring for the elderly resident in a skilled nursing facility. Future plans to establish hospital-based nursing home units must consider the benefits resulting from easy access to acute health care and educational programs against problems of hospital bacterial flora, among other factors.

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Perinatology
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Breast milk jaundice: An evolving tale

Gary R Gutcher, MD, Madison, Wisconsin

EDITORIAL NOTE. *It has been a common observation that breast fed infants frequently remain longer in the nursery than formula fed ones as a result of persistently elevated blood levels of bilirubin. An article by Doctor Angelis, et al, published in 1980 in this Journal discussed general clinical aspects of the syndrome of breast milk jaundice. The accompanying article describes the theories about the etiology of such breast fed milk jaundice and also outlines a plan of treatment.*—LBC

FOR NEARLY TWENTY years, pediatricians have had the clinical impression that some breast-fed babies became jaundiced for a longer period than did formula-fed babies. A now well-established clinical syndrome has been described by several investigators:[1,2,3] while no difference in serum bilirubin can be detected at three days of age,[4,5] a significant difference appears by day five of life[5] in about one percent of breast-fed infants when compared to bottle-fed infants. The level of unconjugated serum bilirubin rises to a maximum at about two weeks of age, levels off for about two weeks at 15-25 mg%, and then slowly declines to normal levels by 4 to 12 weeks of age. The association of this form of jaundice with breast-feeding has been strengthened by the observation that the cessation of breast-feeding at any stage results in a prompt and rapid fall in the serum bilirubin. Further, if feedings are resumed before the serum bilirubin falls to normal levels, the rapid decline is blunted and, indeed, the bilirubin level may actually increase 2-3 mg% before continuing its inevitable slow decline.

One of the original descriptions of the syndrome[6,7] demonstrated the inhibitory effect of breast milk on the *in vitro* conjugation of bilirubin by liver slices. Investigators subsequently isolated a progestational steroid, 3-α, 20β-pregnanediol from breast milk which inhibited glucoronyl-transferase in guinea pig liver microsomes. However, others[8,9] have been unable to isolate this hormone from the milk of mothers with affected infants while yet other laboratories have been unable to reproduce the work demonstrating an *in vitro* inhibition of conjugation by pregnanediol.[10,11,12] Furthermore, the oral administration of the hormone to infants has resulted in insignificant rises in serum bilirubin concentrations.[8] Subsequently, pregnanediol was shown to inhibit the release of conjugated bilirubin from the liver cell[12,13] rather than enzymatic inhibition—an effect that should produce a conjugated hyperbilirubinemia rather than the observed unconjugated hyperbilirubinemia.

More recently, investigators have demonstrated that unsaturated free fatty acids inhibit glucoronyl-transferase *in vitro*.[14,15,16,17,18,19] It appears that the milk of mothers with affected babies have high levels of lipase activity. Most of this lipase activity in human milk resides in a bile-salt-stimulated enzyme which is found in the whey protein fraction. Much of the remaining lipase activity is attributable to a serum-stimulated lipoprotein lipase. While the infant's own pancreatic lipase is only capable of hydrolyzing triglycerides to 2-monoglycerides and free fatty acids, the lipases in breast milk are capable of complete hydrolysis of triglycerides to glycerol and free fatty acids. These lipases are also relatively active in the mildly acidotic (pH 6.0) postprandial gastric contents of the newborn. Furthermore, the resultant glycerol is easily absorbed by the stomach.

Thus, it has been proposed that breast milk jaundice results from breast milk containing high levels of non-bile-salt-stimulated lipase activity which acts in the infants stomach to yield high intraluminal levels of glycerol and free fatty acids. Since the glycerol is readily absorbed in the stomach, the infant's duodenum is presented with a relatively large load of free fatty acids with no readily available source of glycerol for re-esterification. Consequently, large amounts of free fatty acids are absorbed into the portal circulation where they either directly inhibit glucoronyl transferase[14,15,16,17,19] or saturate the Z protein carrier system.[18] Both of these mechanisms would presumably produce an exaggerated hyperbilirubinemia. Some support for this mechanism is rendered by the observed increase in the inhibitory activity of breast milk

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which is frozen or allowed to stand at room temperature. Free fatty acid levels are increased in both instances. At the same time, sterilized milk (autoclaved at 56 C) does not demonstrate increased free fatty acids or increased inhibition of glucoronyl transferase[14] presumably as a result of heat inactivation of the lipase.

A clinical variant of breast milk jaundice has been described in Navajo Indians.[10] In this group investigators have described a high incidence of breast milk jaundice associated with the appearance of an inhibitor in the colostrum and breast milk during the first three days of life. Here the degree of jaundice is related to the level of detected inhibitors.

These studies are all fascinating; however, many unanswered questions remain. From a practical point of view and, fortunately for the infants, their mothers and their physicians, treatment is relatively simple—temporarily withhold breast-feeding. When the serum bilirubin exceeds 20 mg%, most physicians would probably agree that the healthy breast-fed infant is at less risk of developing kernicterus than the sick infant with hemolytic disease of the newborn. However, few would be willing to accept any risk when the therapy is relatively simple. Once a term healthy infant has a serum bilirubin that exceeds 13 mg%, a physical examination and laboratory studies should be done to exclude the possibility of other pathologic causes of neonatal hyperbilirubinemia. When these are reasonably excluded and the serum bilirubin exceeds 15 mg%, replacing breast milk with formula should be instituted for two to three days. A rapid fall in the infant's serum bilirubin during those two to three days confirms the diagnosis. It is imperative that the child's mother be reassured that the cessation of breast-feeding is temporary and that she be encouraged to manually or mechanically express her milk during the therapy trial. Furthermore, she may be reassured that even though her milk *may* be the cause of the problem, the problem is transient and her child will shortly be able to resume feeding at breast. Usually one trial of withholding breast milk for two to three days is sufficient; an occasional infant may "rebound" once or twice and require repeated withholdings. Rarely, phototherapy or exchange transfusion may be necessary.

Finally, there is considerable evidence that breast milk jaundice, properly treated, has no long-term deleterious effects. Thus, it is desirable that parents be reassured on this account so that the family unit is not further stressed by anxiety.

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Membership statistics: Looking good

Everything's coming up roses for SMS membership recruitment and retention in 1981. SMS Membership Department reports that the Society is up 97 members over last year. Total membership at the end of 1980 stood at 4748 while 1981 membership to date is 4845. These figures are especially significant in light of the fact that the membership year now ends on May 15 as opposed to October 15. This means SMS members were required to pay their dues by May 15, 1981 or be dropped from membership. SMS has set membership goals of 99% membership retention and 3% net new member growth for each year. ■

Reduced Practice or Retired Membership Classifications

The State Medical Society reminds physicians who have reduced their practice to 1000 hours or less during the calendar year, but do not qualify for Retired Membership, that they may apply for a "Part-time Practice" classification which waives 50 percent of the regular membership dues.

In addition, the Society reminds physicians who have reached age 70, but are still practicing, that they now qualify for "Over Age 70" classification and will receive a reduction of regular dues by 50 percent.

These special membership classifications must be applied for through the physician's county or state society. The changes will become effective January 1 following approval or the year after the physician reaches the age of 70 and cannot be made retroactive.

Other classifications which may be requested for which dues exemptions may apply are:

Associate: illness or financial hardship

Retired: works less than 240 hours per year

Military Service: temporary service in the Armed Forces or National Health Service

Some county societies have reduced or waived dues for the same classifications as the State Medical Society, also the American Medical Association.

The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classifications can be arranged. ■

Membership classifications for new and future physicians

The State Medical Society of Wisconsin is asking new and future physicians to become a part of organized medicine early in their careers, including students entering medical school. Changes in Society policy have made this possible by creating attractive dues-reduced or waived membership classifications.

The Candidate member is a new category for medical students and Postgraduate-one. Dues are waived for Freshmen and are only $10.00 for others in this classification.

Resident physicians pay only 10 percent of regular dues.

The physician who is elected to membership in this Society within six months of completing residency, fellowship, or fulfillment of government obligation enjoys a dues reduction of 50 percent for the first year and 25 percent the second year.

The AMA has very low dues structure for the Student Member and Resident Member as well. In addition, to attract new members the AMA has a reduction of dues for the new practitioner of 50 percent for the first year and 25 percent the second year.

Physicians are urged to seriously consider joining organized medicine as early as possible to take advantage of these special membership rates. ■

Spouse physicians take note

Responding to a request of the House of Delegates, the Board of Directors has approved a dues reduction for one physician whose spouse also is a physician as an incentive for both to maintain Society membership. This is to become effective for 1982 dues payable next January 1.

One of the members of such two-physician families would be entitled to a dues break of $50. The other would pay full dues. The members themselves would identify which one receives the discounted rate.

The Society requests that such two-physician families use the home address for mailings so as to assure equal access to the Society's communications. The reduction of dues is supported by eliminating duplication of Society mailings, including the *Wisconsin Medical Journal* and *Medigram.*

Spouse physicians are urged to identify themselves as two-physician families and request the dues reduction of $50 for one member of the family. ■

Teaching awards to be presented at SMS Annual Meeting

The SMS Commission on Continuing Medical Education is in the process of reviewing the "Distinguished Service Award" and the "Erwin R Schmidt Interstate Teaching Award" to be presented at the 1982 SMS Annual Meeting, May 13-15.

The Distinguished Service Award is given on occasion "to recognize outstanding contributions to the science and art of medicine by individuals engaged in teaching and research in the basic sciences."

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The Erwin R Schmidt Interstate Teaching Award is given by the Interstate Postgraduate Medical Association, upon recommendation of the CME Commission, to "a faculty member of one of the two Wisconsin medical schools who has distinguished him/herself as a teacher of medical students and in preparing them for both the art and science of medicine."

(Note: The 1981 Interstate Postgraduate Meeting will be held October 26-29 in Atlanta, Georgia.)

Any physician with potential nominees for these awards should contact Leonard Wurman, MD, in Wausau at 715/845-9634 or Bill Wendle at SMS offices toll-free at 800/362-9080 or in Madison at 608/257-6781. ■

How to write a vignette

The Aesculapian Society of the State Medical Society's Charitable, Educational and Scientific Foundation is looking for contributions for its "Vignette Book"—a collection of warm, human interest sketches of deceased Wisconsin physicians. The aim of the vignette project is to reflect a true picture of Wisconsin medical history by receiving one vignette from each county (see box below).

Deborah Erwin, who chairs the Vignette Book Project for the Aesculapian Society of the State Medical Society's CES Foundation, offers the following advice to those interested in the project.

Vignettes are impressions and recollections—a little picture—of the person. They are more anecdotal than biographical. The theme is the personality of the doctor, not just a listing of his or her educational and professional accomplishments. Biographical data can be woven into the story, but it should not be emphasized.

Who writes a vignette? How does one get started? Anyone—family members, friends, former students, associates and colleagues, "historians," or just an interested person—can write a vignette about deceased Wisconsin physicians—from the medical school researcher to the county practitioner. Talking to area physicians and long-time residents is a good way to decide whom to write up in a sketch.

Once the decision is made whom to write about, how does one find material on the physician? Contact the local and state historical societies and begin digging around in the old files. Talk to people at the local medical society office, the hospital public relations department, or the medical school public relations department. Ask the librarian. Check the files at the area newspapers. Talk to community leaders. One thing will lead to another; people get interested and will be quite helpful. The job is easier if the writer is someone who knew the doctor

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VIGNETTES IN PRINT (by County)

Ashland
John M Doff, MD
C J Smiles, MD

Barron
W B Hopkins, MD

Brown
Leonard Miller, MD

Buffalo
Phillip Bouffler Amunson, MD

Dane
Phillip Fox, MD
Phillip R Fox, MD
Cornelius Harper, MD
William S Middleton, MD

Dodge
A W Jones, MD
John Reynolds Jones, MD
George E Swan, MD

Douglas
Thomas J O'Leary, MD

Fond du Lac
Mason C Darling, MD

Grant
Wilson Cunningham, MD

Jackson
Eugene Krohn, MD

Juneau
James S Hess, MD

Kenosha
Nelson A Pennoyer, MD

Kewaunee
William Wencil Witepalek, MD

La Crosse
E S Carlson, MD
Adolf Gundersen, MD
Archie Skemp, MD
Perry Trowbridge Walters, MD
Frederick H Wolf, MD
Herman E Wolf, MD

Marathon
Merritt LaCount Jones, MD
Frederick Kroeplin, MD

Milwaukee
James P Conway, MD
Eleanor Delfs, MD
Max J Fox, MD
Roman E Galasinski, MD
Ernest O Henschel, MD
Joseph M King, MD
Francis D Murphy, MD
Armand J Quick, MD
James Clyde Sargent, MD
Nicholas Senn, MD

Monroe
DeWitt Clinton Beebe, MD

Oconto
Joseph S Dougherty, MD
Jacob Gomber, MD

Oneida
Kate Newcomb, MD

Outagamie
Henry W Abraham, MD
Charles D Boyd, MD
Everett H Brooks, MD
Albert E Rector, MD

Pierce
Clair R Cannon, MD

Polk
Raymond G Arveson, MD

Racine
Louis Edward Fazen, Sr, MD

Richland
Bertha Reynolds, MD

Sheboygan
Leslie W Tasche, MD

St Croix
Doctor Blom
Doctor Stockman
Frank Wade, MD
Frank Epley, MD
O Hoyt Epley, MD
Joshua H Armstrong, MD

Trempealeau
Henry A Jegi, MD
William McKowan Young, MD

Waupaca
Fred Pfeifer, MD

Winnebago
F Gregory Connell, MD
Charles William Oviatt, MD
Henry A Romberg, MD
Isaac H Wright, MD
Aaron B Wright, MD ■

and can reminisce about the "old times." Be sure to give the writer a "credit line" at the end of the story. Also, tell his/her relationship, if known, to the physician in the sketch. It's a good idea to have the family approve the sketch. This is not always possible, of course. A credit also must be given to any printed "borrowed" material.

There is no such thing as a "typical vignette style." Some vignettes are humorous, some are serious. The writer sets the tone. A good guide to follow is the style of a newspaper or magazine story about a person.

Please make the article two to three typed (double-spaced) pages long. Some editing will be done. Try to include a photograph or snapshot of the doctor, but be aware of the fact that it will be used as illustration and will not be returned.

Send the finished sketch and picture to: The Vignette Project, Aesculapian Society, SMS, PO Box 1109, Madison, WI 53701. Be sure to include your name and address.

The Vignette Book can be seen during the summer months at the Fort Crawford Medical Museum in Prairie du Chien; in winter it is kept in the Board of Directors Room at Society headquarters. We invite you to read it at either place. The Book is not available for loan. ■

43 Med students participate in externship program

"Many things were a first for me—surgical experience, witnessing the birth of a baby, the victims of severe trauma, the death of an old man—these I will not forget. . .One difficult aspect of the (Summer Externship) Program was leaving behind the patients that I had come to know and like, enjoy working with to see their week-to-week progress. I wonder how they are doing now. . .Let me close by thanking your organization and those who made this experience possible for me. I consider it a very valuable part of my medical education—something that I'll be able to give back in terms of patient care when I get 'out there' in practice someday."

Notes of a Summer Medical Student Extern, 1981

The above words summarize quite well the reaction 43 freshman medical students had regarding their eight weeks of living and working with a family physician under the Summer Externship Program. The program, now in its 13th year, is designed to acquaint the medical student with family medicine, particularly as it's practiced in a rural area of Wisconsin.

The program is sponsored by the Wisconsin Academy of Family Physicians and is funded by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin. Other contributors to the program are: Wisconsin Rural Rehabilitation Corporation, Blue Cross & Blue Shield United of Wisconsin, American Family Insurance, Wisconsin Physicians Service, Wyeth, Inc, and Wausau Insurance Companies. In addition, individual physicians have contributed over $150,000 since the program's inception.

Under the program a medical student from either the University of Wisconsin Medical School or the Medical College of Wisconsin is matched with a practicing family physician. Beginning in June the student spends a minimum of eight weeks working alongside his preceptor-physician, learning as much as he or she can about caring for individual patients and their families, learning to function in a community hospital, and learning how to utilize the various health resources in the community.

Since its inception in 1969, the Summer Externship Program has provided an excellent learning experience for over 600 medical students from the two schools in Wisconsin, several of whom have now finished their undergraduate training and are now in a family practice residency program, preparing to enter family medicine in some Wisconsin community, or currently practicing in Wisconsin. This indeed, is the long range goal of the program. . .to attract young medical students to practice in Wisconsin communities where there is major need for family doctors.

Listed below are the physicians or medical group and students who participated in the program this summer.

Physician/Medical Group	*City*
Student	*School*
Donald Bates, MD	Ft Atkinson
Mark Hansen	UW
Donald Beaver, DO	Milwaukee
Wendy Hanneman	UW
Donald Blink, MD	Eau Claire
Jeff Blink	UW
Janis Byrd, MD	Sun Prairie
Diane Carpenter	UW
Chester Crawford, MD	Green Bay
Christina Grieben	MCW
Gerald Derus, MD	Madison
Charles Strachan	UW
Joseph Devitt, MD	Milwaukee
Steve Hoy	MCW
Doctors Clinic	Wisconsin Rapids
Mary Jean Hoppa	UW
Richard Ellingstad, MD	Burlington
Evelyn Burdick	MCW
Donald Evans, MD	Merrill
Justin Bubolz	UW
Michael Garrity, MD	Prairie du Chien
Randy Kieser	UW
Stuart Goldman, MD	Milwaukee
Thomas Puchner	MCW

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William Halloran, MD Melanie Schultz	Milwaukee MCW
Glen Heinzel, MD Dean Smith	Oconto MCW
Donald Heyrman, MD James Spencer	Menomonee Falls MCW
John Honish, MD Edward Kinney	Oconto UW
James Ickon, MD Charles Hansell, MD Karin Madsen	Columbus UW
Dorothy Jayne, MD Toni Iofino	Mukwonago MCW
M S Kochar, MD Judith Thompson	Wood MCW
John J Koch, MD Susan Blase	Prairie du Sac MCW
Olilia A Marina, MD Mary Braza	Madison UW
John McKinchan, MD Bruce Abrams	Platteville UW
Medical Associates Frank Sheski	Baraboo UW
Mukwonago Family Physicians Cyril Severns	Mukwonago MCW
R N Nesemann, MD Michael Meyer	Kewaunee UW
James Pawlak, MD Ruth Decker	Sheboygan MCW
Thomas Peterson, MD John Feldmeyer	Wausau UW
Robert F Purtell Jr, MD Maurice Chung	Milwaukee MCW
Joseph Rienstra, MD Lois Hess Gary Helmbrecht	Brookfield MCW MCW
Melvin H Rosen, MD Joan Zinkgraf	Waunakee UW
F M Schammel, MD Gina Adel	Stoughton UW
Gary Schmidt, MD Tom Paulson	Manitowoc MCW
Roger Strube, MD Mary Streetman	Milwaukee MCW
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SMS testifies on mandatory coverage bills

SMS representatives were busy last month testifying before the Assembly's Committee on Insurance, Cooperatives, and Risk Management on two bills calling for insurance coverage of psychologists' and optometrists' services.

Pauline M Jackson, MD, who chairs the SMS Committee on Mental Health, spoke in opposition to AB 422 which would extend medical assistance coverage to licensed psychologists without requiring referral or consultation with a physician. Doctor Jackson pointed out to the committee that the bill was based on the faulty premise that psychiatrists and psychologists offer the same or similar services and therefore the patient should be offered "free choice" of provider.

"A psychiatrist's time is spent, for the most part, treating medically complicated mental problems," Doctor Jackson said. "Psychologists have well-defined roles and are necessary members of the treatment team, but they are not trained to diagnose or treat medical illness, to dispense drugs, or to supervise clinical treatment."

The Society also offered testimony July 23 in opposition to a bill which would prohibit an insurance plan from excluding coverage for services or procedures provided by an optometrist if the "same" procedures are covered when provided by another healthcare provider. AB 413 recently has been recommended for adoption by both the Assembly and Senate Insurance Committees. The Psychology Bill, AB 422, has been held over by the Assembly Insurance Committee pending further information from bill author David Clarenbach (D-Madison). ■

SMS protest brings corrective action

In late July SMS Secretary Earl Thayer issued a letter to State Dept of Health and Social Services Secretary Donald Percy charging that DHSS-contracted auditors had used unethical tactics in auditing the Medicaid practices of certain physicians' offices and clinics.

A medical clinic, which had been the object of a DHSS audit, reported to the Society that the auditors sought to explore not only Medicaid records but also general business information such as the total number of persons employed by the clinic, their salaries and fringes, and rent and overhead costs of various types.

Division of Health Administrator Ken Rentmeester has now informed the Society that the Department has formally directed the auditing firm, JL Trainor Co, to request only those records which are "directly necessary to verify: a) the actual provision of [Medicaid] services, and b) the accuracy and appropriateness of the provider's billings for those services."

Rentmeester, in a letter to SMS Secretary Thayer said: "I assure you neither the Department nor the audit contractor will encourage, condone or permit the request or examination of provider records which are irrelevent to the provider's Medicaid practice. It must be noted, that although the auditors previously had requested access to records only tangentially related to the providers' Medicaid services and billing efforts, they have at no time requested access to private pay medical records."

Despite assertions by the Department that private pay patient records had not been requested, SMS has information which indicates such records had in fact been requested by the thousands. In one location alone, more than 1500 private patient records were requested. ■

Medical Society cites flaws in alcohol, drug standards

"The treatment of any disease, including alcoholism, must be under the supervision of a physician; to turn the responsibility for medical care of a medical illness to non-medically trained personnel is a risky step and ought not be sanctioned by state government," a spokesperson for the State Medical Society said recently.

Michael C Gordon, MD, a member of the State Medical Society's Committee on Alcohol and Other Drug Abuse and a medical director of the Anderson Alcoholic Rehabilitation Hospital, voiced several concerns of the medical profession in regard to the newly proposed standards for community alcohol and other drug abuse treatment and prevention programs at a public hearing in Madison.

Doctor Gordon pointed out that "the authors of the standards were under the mistaken belief that alcoholism is a social or behavorial problem rather than a disease, as is the accepted definition." He disagreed with the authors that alcoholism was not an "intentional act" as they state, but rather, it is a condition in which the afflicted individual has lost control over his or her use of alcohol or other mind-altering drugs with the resultant development of serious problems in areas of physical or mental health or spiritual or social well-being.

There is also a lack of clarity about what constitutes "treatment" as opposed to "rehabilitation," Doctor Gordon charged. By lumping "therapeutic communities," (*ie,* heavily staffed, intensive rehabilitation programs for drug abusers) with "transitional facilities" (*ie,* halfway houses) the Bureau of Alcoholism and Other Drug Abuse is "sanctioning a halfway house as treatment for alcoholism and is condoning the bypassing or true, definitive rehabilitation efforts in the name of cost-effectiveness," he said.

continued next page

Doctor Gordon also expressed concern about nonmedical detoxification program standards which did not require any staff to be present 24 hours a day, only "available."

"What is called detoxification really amounts to nothing more than a 'sleep-off' service—a place where intoxicated individuals can sleep-off their intoxicated state under minimal supervision of medically untrained persons," he said.

These same standards state that individuals will only be admitted to nonmedical detoxification only after examination by "trained staff" and as long as they do not require professional nursing or medical care.

"It is presumed that the 'trained staff' delegated to conduct the examination is going to make these decisions," Doctor Gordon said, "as well as who requires medications normally used for the detoxification process."

"These decisions would normally fall under the umbrella of practicing medicine," Doctor Gordon said. "Is the State really ready to grant nonmedically trained personnel the authority to make this type of decision?" ■

September 11: Cut-off date for psychotherapy payment

The State Department of Health and Social Services (DHSS) has decided it will stop paying all claims for outpatient psychotherapy and alcohol and other drug abuse services (AODA) under the Medical Assistance program on Sept 11, 1981. (September 10 is the last "date of service" which will be paid.) In addition, all requests for prior authorization will be denied effective Aug 5, 1981. This elimination of outpatient psychotherapy was one of 121 line item vetoes in the budget made by Governor Lee Dreyfus in late July.

September 11 was chosen as the cut-off date because DHSS is obligated to advise Medicaid recipients in writing of the elimination of any benefit. That notice was sent to all recipients with their medical assistance cards in August. The ten-day "grace" period is also a federal requirement.

The affected codes, taken from the Medical Assistance Provider Handbook, are as follows:

Individual Psychotherapy	*Group Therapy*	*Family Therapy*	*Collateral Interview*
90841	90853	90847	90887
90842		90848	
90843		90849	
90844			

At the present time, psychiatric evaluations (90801) and medication checks (90862) remain covered services, but the Department is considering the elimination of these services as well. Physicians will be notified of any change in the status of these services.

With physician services mandated by federal law, and psychotherapy/AODA services now eliminated as covered services under the Medical Assistance Program, there exists a conflict over what a psychiatrist may bill and be reimbursed. DHSS has not yet decided how it proposes to resolve this issue. SMS believes "physician" services remain a covered benefit under Medicaid, and may contest an adverse decision by DHSS.

While Governor Dreyfus originally proposed the elimination of outpatient psychotherapy in his budget, the SMS Physicians Alliance and others worked to have it restored in the Assembly. The Legislature will not consider the Governor's veto until October, at which time a two-thirds vote in each house is necessary to reinstate the service. Physicians with questions regarding this issue should contact the Physicians Alliance staff toll-free at 800/362-9080 or in Madison at 608/257-6781. ■

CES FOUNDATION

CONTRIBUTIONS—JULY 1981

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for July 1981.

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Seminar for helping impaired physicians set

In recent years there has been increasing reference in the literature, and increasing attention at conferences, to the general subject of the impaired physician and how such a physician can be successfully rehabilitated and returned to a productive practice of his or her profession.

For perhaps the first time in Wisconsin, a conference dealing with identification, prevention of impairment, intervention, and rehabilitation of impaired physicians will be held at the Holiday Inn, Waukesha, on October 14 and 15. The program, which provides 9.5 hours of continuing medical education credits for Category I, is being sponsored by the Coordinating Council on Physician Impairment, a joint activity of the State Medical Society and the Medical Examining Board.

The Coordinating Council was created two years ago to coordinate activities of the Society and the Board in identifying and assisting physicians impaired by alcohol, other chemical abuse, mental illness, or senility. The program is being sponsored in cooperation with Mt Sinai Medical Center of Milwaukee.

Although the seminar has been designed specifically for information of hospital board members and administrators, hospital chiefs of staff, county medical society officers, and clinic representatives and managers, all members of the State Medical Society are invited to attend.

This program is designed to:

. . .provide information on prevention, intervention, and subsequent rehabilitation of the impaired physician—physically and emotionally;

. . .present the wide range of individuals, institutions, and agencies in Wisconsin that may be involved with the impaired physician and his or her problems and concerns;

. . .identify and contact those individuals who are willing to become involved in initiating and maintaining an awareness of the various impaired physician programs.

A Wednesday morning panel on "Prevention-Stress Points" will look at medical education, medical practice and medical marriages, professional burnout, and physical impairment.

In the afternoon the role of psychiatrists, hospital administrators, the State Medical Society, county medical societies, the Medical Examining Board, professional peers, and hospital staffs will be discussed in relation to "Intervention-Confrontation and Coordination."

The final portion of the program, on Thursday morning, will be devoted to "Rehabilitation-Detoxification, Re-education and Re-entry" in regard to chemical dependency and educational, physical, and psychiatric impairments.

Program participants include: ***Joanna Spiro, EdD,*** Assistant Professor of Psychiatry and Mental Health Services, Medical College of Wisconsin; ***Barry Blackwell, MD,*** Chief of the Department of Psychiatry of Mt Sinai Medical Center; ***Ervin Teplin, MD,*** Clinical Professor, Department of Psychiatry, Medical College of Wisconsin; ***Albert A Fisk, MD,*** Medical Director, Wisconsin Regional Geriatric Center; ***Richard H Strassburger, MD,*** Chief of Staff, St Luke's Hospital, Milwaukee; ***Rudolf W Link, MD,*** Psychiatrist and Co-chairman of the Coordinating Council on Physician Impairment; ***Daniel Kane,*** President, Mt Sinai Medical Center; ***Gerald C Kempthorne, MD,*** President-elect, State Medical Society and Co-chairman of Coordinating Council on Physician Impairment; ***Charles W Landis, MD,*** President, the Medical Society of Milwaukee County; ***Gwen Jackson,*** a member of the Medical Examining Board of Wisconsin; ***HB Maroney,*** Assistant Secretary and Corporate Legal Counsel of the State Medical Society; ***Roland E Herrington, MD,*** Corporate Medical Director, De Paul Rehabilitation Hospital, Milwaukee; ***Willard M Duff, PhD,*** Associate Dean for Continuing and Allied Professional Education, Medical College of Wisconsin; ***Betty Jo Maly, MD,*** Assistant Professor of Physical Medicine and Rehabilitation, Medical College of Wisconsin; ***Clifford J Simske, MD,*** Medical Director, Milwaukee Psychiatric Hospital, Wauwatosa.

Representing the State Medical Society of Wisconsin on the Coordinating Council on Physician Impairment are Gerald C Kempthorne, MD, Spring Green (Co-chairman); John B McAndrew, MD, Oshkosh; and Harry F Weisberg, MD, Milwaukee.

Representing the Medical Examining Board are Rudolf W Link, MD, Madison (Co-chairman); Gwen Jackson, Milwaukee; and Walter L Washburn, MD, Madison.

The seminar will begin at 8:30 AM Wednesday, October 14, and reconvene for the morning of October 15. Registration can be made through the Coordinating Council on Physician Impairment, Attn: John LaBissoniere, PO Box 1109, Madison, WI 53701; or phone (608) 257-6781 at State Medical Society headquarters in Madison. ■

Premarital blood test requirement struck down

The state law requiring premarital blood tests and physical examinations was struck down last month when the Legislature passed the biennial budget bill. The law had been the subject of considerable controversy in recent months as county clerks in the state had expressed concern over the extent of physical examinations given couples under the requirement. The SMS Committee on Maternal and Child Health called for repeal of the law last May since only three cases of syphilis a year were being detected out of more than 80,000 persons who are married each year in Wisconsin. The effective date for the change is October 29. ■

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SEPTEMBER 1981

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Facts

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
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The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
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President's Page

ALBERT J MOTZEL JR, MD

The rationing of medical care PART II: Where we are!

Is there any limit to the amount of 'free' medical care that a given population can absorb?

THIS IS THE question raised by the continuing increase in the proportion of the Gross National Product (GPN) spent each succeeding year on medical care. As we consider this increasing proportion or relative increase in the total cost, in contrast to the perception that the individual service costs us little or nothing out of pocket, the paradox requires explanation. Unlike those other goods and services which individuals purchase for their enjoyment or welfare such as entertainment, food, and shelter, and pay for directly, much medical care is, for the vast majority, a *very* indirect expense. There is in fact great pressure to shift medical care away from the area of direct payment on the part of the consumer whenever a significant cost is involved (for example emergency rooms, hospitalization, and so forth).

Nor is the physician particularly uncomfortable with this arrangement. It removes a great concern and significant pressure from the physician if each test and each recommendation does not have to be so agonizingly evaluated in terms of cost effectiveness. It is not a matter of careless ordering of unnecessary studies, but a constant question of "can the patient afford" the really significant but expensive evaluation desirable? In our time this problem has become further complicated by the necessity of "overlooking nothing" in our litigious society (*ie,* defensive medicine) as demonstrated by the costs added to medical care by medical liability insurance.

As insurance became more prevalent, and especially as employers began to pay an increasing proportion of that cost, the early indemnity fee schedules for surgical procedures have given way to the UCR (usual, customary, and reasonable) concept, as well as payment for the more difficult to define "medical" care. Because insurance carriers and their physician advisors feared the cost of financing the least defined and least measurable aspect of care—the office visit or procedure—the methods of insurance payment served to drive patient care in the direction of hospitalization where it was assumed that greater standardization and quality control would exist. While this assumption is understandable, it is certainly true that much care of the highest quality is equally available in private offices and clinics without the added cost of hotel services, standby nursing care, and diagnostic facilities where they are not needed.

If then, added to the highly desirable ability to diagnose and successfully treat are these many pressures for increase in cost, what methods are available for controlling this cost of care? Let us consider the following possibilities:

1. Limitation of physicians' fees,
2. Limitation of patient use of facilities by the physician,
3. Limitation of the development and distribution of new technology,
4. Limitation of hospital bed capacity,
5. Limitation of eligibility of patients for use of technology.

Limitation of physicians' fees has potential for only limited saving because of the relatively small proportion of the total cost of medical care accounted for by these fees. Also, while virtually no one would dispute the impropriety of an exorbitant or disproportionally high fee, it may be counterproductive to reduce the income potential for those who are supposed to control the total costs of care by their judgment and expertise in the judicious use of diagnostic and treatment services. Certainly this would be true if that reduction would leave other avenues of creative activity more attractive to the best of our potential practitioners. In addition no effective means of controlling physicians' fees now exists. While some programs (Medicaid) do limit fees, participation is not mandatory. Various HMO programs have potential in this regard, but their primary thrust is again to utilize the expertise of the practitioners to reduce the cost of hospitalization.

Strict limitation of patient use of medical care by the physician (the "gatekeeper" concept) is increasingly emphasized but is difficult to effect. Fre-

quently the perfect cost-effective choice is not clear. In addition the physician is exhorted by the patient and family to spare no cost that might be helpful. The physician himself feels morally obligated to produce the best result for the patient. Finally, the vote-seeking politician and the fee-seeking attorney make it abundantly clear to the patient that no increment of cost is legitimately to be spared in the pursuit of the perfect outcome of care. This is the standard of society today.

Limitation of development and distribution of new technology and limitation of bed capacity is already with us in the form of "certificate-of-need" legislation. Unfortunately its application is thus far fraught with politics and misjudgment. Today some costs are higher because the real value of some expensive technological development was underestimated by an over-zealous, cost-conscious administrator. Most, if not all, of any legitimate saving has been exceeded by inflationary delay and administrative cost. This must seem like a poor trade off to all but those receiving the administrative salaries involved. The ultimate outcome of this process of the control of modernization and new technology is best demonstrated in England by "rationing by delay." It is possible to reduce the overall need for medical care by delay until the problem has either temporarily improved or progressed beyond the ability to treat.

The final method of reducing cost is the ultimate denial of service to an individual on the basis of some defined eligibility requirement. For example, the denying of certain modalities of treatment (cardiac or vascular surgery, or renal dialysis) on the basis of physical factors definable in the patient (age, diabetes, and so forth). While this method of rationing procedure seems unthinkable now, it is perhaps the natural and ultimate conclusion in the control of the total cost of "free" medical care. It is this threat that is probably most discounted in discussions of cost containment today and yet it is the most obvious and easily applied even though the most dangerous and machiavellian of all solutions. If the bureaucrats could devise a system by which these criteria could be attributed to the physician community, such a system would probably exist very quickly.

Is there any other alternative? ■

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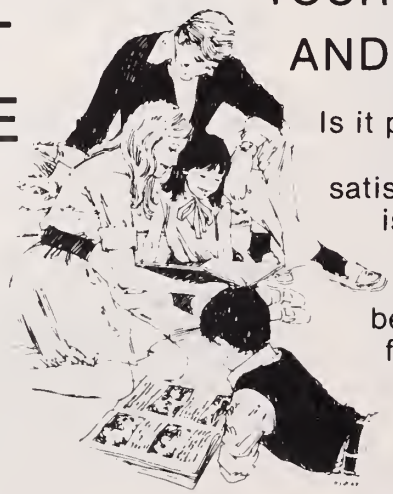

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Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Ambulatory surgery under duress

UNDER THE CURRENT intense pressure to cut costs, it should come as no surprise that the federal Health Care Financing Administration and some insurance carriers have cast fond eyes on ambulatory surgery. Government, of course, already characteristically hints at paying only that amount for an operation which would approximate the usual and customary cost of the surgery if it had been done on an outpatient.

One foresees the situation, for instance, where inguinal herniorrhaphy becomes known as an outpatient procedure—a perfectly legitimate situation for a young, healthy individual under ideal circumstances. But soon, rules are laid down which require that all hernias be repaired under those conditions without regard for such crucial factors as the age and general state of the patient's health. (Of course, exceptions will be allowed if permission is secured in writing before the fact, from the appropriate bureau.)

The possibility of just such an occurrence is not far-fetched. The AMA and the American College of Surgeons have already expressed negative reactions. It would be wise for those of our colleagues who advise government agencies and insurance carriers to speak up now and insist that the choice of setting in which an operation is to be performed must be made in the best interest of the patient by the attending physician and must not be influenced by monetary considerations. —WJB

Uniform fees

AT ITS JULY meeting, the SMS Board of Directors was given an interesting opportunity to test the attitude of the Federal Trade Commission (FTC) with regard to the establishment of uniform physician fees. In past years whenever the topic has come up for discussion, the threat of FTC action on grounds of price-fixing has been enough to dampen the enthusiasm immediately. This time, however, the impetus was provided by a new source—Martin Preizler, director of the state's Bureau of Health Care Financing, who had proposed formation of an unofficial committee of physicians to meet with the State Department of Health and Social Services periodically to offer advice and opinions on reimbursement options, including a "uniform fee methodology."

The Executive Committee of the Board, after extensive debate, recommended to the SMS Board of Directors the authorization of a nominating committee to select a number of physicians to work with the DHSS toward that end—not exactly earth-shaking, but at least a start—and the Board reaction seemed favorable. But once again the Society legal counsel pointed out that, in essence, the establishment of uniform fee methodologies constitutes price-fixing. So once again the Board backed off; and although it approved the recommendation of the Executive Committee, it stipulated that the group of physicians selected would have to act as individuals so as not to be interpreted as acting as representatives of the State Medical Society of Wisconsin.

I find that hard to understand.

If the Board of Directors of the State Medical Society doesn't instruct its members on matters relating to fees, it is abrogating its responsibility to its members and to its patients. The public is being bombarded on all sides these days with news releases and "Sixty-Minute"-type documentaries on the high cost of medical care, but it receives no guidelines on what a fair fee really is. The same can be said of many specialists—they don't seem to know what a fair charge is, either. Why can't a body which represents medicine in this state tell them? If the FTC doesn't see it that way, then it should be challenged in court if necessary. —WJB

GAO and the budget

ACCORDING TO THE AMA Legislative Roundup, the General Accounting Office (GAO), the faithful watchdog over federal spending, sharply criticized two health programs administered by the Department of Health and Human Services. In reviewing the Health Planning Program which had funding of $750 million and community effort in addition, the GAO reported that the health system plans (HSPs) were considered inadequately developed and did not represent a good framework for making needed changes in the health care systems. GAO concluded that the HSPs were generally "totally unusable" and waste a "considerable" amount of money, and recommended that health plans be done, if at all, at the state level.

The GAO was also highly critical of the Community Health Center programs designed to provide service in underserved areas.

There are drastic reductions for health planning in the new federal budget. Grants to HSAs (Health Systems Agencies) will be cut to $65 million, down from the current $185 million authorization. Grants for state agencies will be cut from $45 to $35 million, and grants to the Centers for Health Planning will be cut to $2 million from the current $10 million.

The dollar "triggers" for certificate-of-need (CON) review have been sharply stepped up. Major medical equipment was increased from $150,000 to $400,000, institutional health services from $75,000 to $250,000, and capital expenditures from $150,000 to $600,000. The new legislation will also extend the deadline for states to enact complying CON laws to one year beyond the current deadline.

This decrease in the federal funding should certainly curtail some burgeoning bureaucracies. —VSF

Cost containment decision-making

THE PHRASE COST CONTAINMENT has become increasingly popular in the past year or so; and at the Annual Meeting earlier this year the State Medical Society's House of Delegates formalized this popularity by a resolution introduced by the Brown County Medical Society favoring cost containment. The one unifying hypothesis is do not do anything "unnecessary."

In a clinic large enough to have a business manager, the first problem of this manager is to acquire for himself approximately $25,000 to $35,000 per annum. How does he do this? He does not see patients, he does not deliver an identifiable service for which a patient can be billed directly. Therefore, he must acquire a source of income in the clinic from which he can receive his annual compensation. Usually this is accomplished by organizing the clinic into a system where the clinic manager is put astride the cash flow but does not directly diminish the pay of the employer/physicians. This is done by operating other little industries such as a medical laboratory, a pharmacy, and an x-ray department.

Developers of clinic facilities are quick to point out the financial advantages of a laboratory, pharmacy, and x-ray department in their prospectus for a medical arts building even in the planning stages. They point to their "mortgage lifting" capabilities.

In all of the meetings regarding cost containment, these cost-generating facilities are strangely excluded. The laboratory tests and x-ray examinations are "unnecessary" only if done in the hospital. The $1.00 aspirin tablet is supplied only in the hospital, apparently.

If you question the need for an x-ray department, laboratory, or pharmacy in a clinic, it is explained they are for the "convenience of the patient" or to "speed result delivery." These explanations are uncritically accepted by physicians and they are delivered by the clinic managers for reasons that may have little to do with the convenience of the patient or the expeditious delivery of medical information.

Indeed, in some localities in Wisconsin several small laboratories may be located in a single medical arts building. The reduplication of x-ray facilities with rather substandard and marginal x-ray equipment is well known to the accrediting and inspecting agencies. The expertise and level of training of medical "technicians" in clinic and private physician

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practice is often questionable. Yet all of these marginal people and equipment are accepted under the guise of "convenience to the patient." The economies of scale of a central laboratory or x-ray facilities are never allowed to operate because of the persistence of the multiple small "profit centers" so dear to the hearts of clinic managers. Walgreens or Oscos are just fine on weekends.

Until the medical community in general stops listening to the people who structured this system of medical care delivery, we shall continue to delude ourselves that we have an economical system.

—RAM

Refugees

THERE ARE NOW more refugees in the world than at anytime since World War II. For example, there are a million and one-half ethnic Somalian refugees from Ethiopia registered in camps and transit centers. There also are two million Afghans who are refugees in Pakistan and an additional 70,000 enter the country every month. More than 70% of these refugees are women and children and there are high levels of tuberculosis, whooping cough, measles, eye infection, and gastrointestinal, skin and parasitic disease. Malaria and malnutrition are also common.

In Uganda it is estimated that there are 360,000 displaced persons due to food shortage as well as political instability. In El Salvador there are 150,000 displaced people, mostly women, children, and elderly persons.

The number of boat people from Southeast Asia doubled in recent months and many of these are badly injured or have been raped by pirates. In Thailand, there are camps for the refugee Laotians and Cambodians.

The situation in Wisconsin is on a relatively small scale. However, in the past five years there have been 9000 refugees from Indochina, 1200 Soviet Jews, 1000 Cubans and Haitians. The federal government has allocated 16 million dollars for refugee care in Wisconsin, exclusive of the Cuban allocation which is determined separately.

Some months ago a call was issued for physicians in the state to offer to help in the care of refugees. The response of individual physicians as well as clinics was gratifying. Although the number of refugees in Wisconsin would average out to only about two for every physician in the state, most of the refugees are located in a few centers. Every physician in the state, who has any contact with the refugees, should make every effort to help these unfortunate people in every humanitarian way. —VSF

Yellow peril—alert

WISCONSIN PHYSICIANS have been receiving a misleading form of correspondence. Both the envelope and the letterhead display open yellow pages. Do not be misled by this as it has nothing to do with the Yellow Pages in your local telephone directory. It is from a national classified directory that is "distributed free to civic or other public institutions at the sole discretion of the publishers."

The charge for listing a name in this directory is $87.00 per year. Apparently some regulatory agency must have clamped down on this publisher because there is a disclaimer printed in pale green stating that "This is not a bill. This is a solicitation. You are under no obligation to pay unless you accept this offer."

Do not be misled by the yellow page logo. This is purely a commercial venture and there is really no good reason that anyone should pay $87.00 to have his name and phone number listed in a worthless directory. —VSF

Wisconsin Medicine, historical perspectives

IN A COMMENTARY elsewhere in this issue, Dr W Bruce Fye alludes in the footnotes to a new book entitled *Wisconsin Medicine, Historical Perspectives.* This is edited by Ronald L Numbers and Judith Walzer Leavitt. Both are from the Departments of the History of Medicine and the History of Science at the University of Wisconsin-Madison and the book was published in August 1981.

The book was appropriately dedicated to the memory of William Snow Miller and William Shainline Middleton, both pioneers of the history of medicine in Wisconsin. The book includes chapters on Frontier Medicine in the Territory of Wisconsin; Medical Practice in Wisconsin, 1848-1930; Sectarians and Scientists; Medical Societies in Wisconsin; Hospitals in Wisconsin; One Hundred Years of Health and Healing in Rural Wisconsin; Health in Urban Wisconsin; and a brief Note on Medical Education in Wisconsin.

For anyone interested in the history of medicine, particularly in Wisconsin, this book is a fascinating account of medical developments in this state.

This new book should stimulate interest in the history of medicine in Wisconsin and perhaps some interesting articles for the *Wisconsin Medical Journal.* —VSF■

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Itinerant surgery. . . continued

TO DOCTOR BOULANGER: Your March editorial on Itinerant Surgery cries for a response. There are several concepts that we take issue with.

①Itinerant surgery *vs* outreach surgery. There is indeed a difference. It appears as if you are talking about outreach surgery and it certainly appears as if the surgeon in Nebraska is performing outreach surgery. The surgeon reaching out does not abandon his patient immediately after surgery as the word itinerant would imply. We feel there is a significant difference and that it is unfair to utilize the label itinerant surgery to include all surgery away from "his home base."

②Your comment "it persists because it is to someone's financial advantage. . ." We feel this is definitely untrue. As you note, local care is indeed cheaper than regionalized care. Furthermore, local surgical care maintains the experience level needed for the local hospital and physicians to maintain high quality care, not only in surgery, but in the medical fields as well. The small town physicians are usually more than busy enough and are not looking for the extra income that the hassle of postoperative care provides.

③You state "but what about the patient?. . . and if the operation carries with it a significant risk, shouldn't the surgery be done in the best possible location?" Reading between the lines, you are implying that big is better. Should not then all surgery be sent to the Mayo Clinic. Should not all myocardial infarctions be sent to NIH. Should not every medical problem requiring hospitalization be referred to a medical mecca. If, however, utilizing "the best possible location" is impossible, a line must be drawn somewhere. Rather than draw that line editorially, present us with some facts that substantiate both the need and the place of that line. We would like to see statistics regarding incidence of infection, mortality rates, morbidity rates, etc comparing the outlying hospital with the regional centers. We feel you will find these statistics show no significant difference in quality *vs* regional hospitals. Far more important than the size or location of a hospital is the ability and knowledge (and continual updating of that knowledge) of the surgeon.

Another factor to consider when dealing with "what about the patient" is what is the patient's desire. Today's patient is knowledgable and can well understand the risks involved in the various types of medical care. I have many times experienced the situation of suggesting referral to a tertiary center and had the patient decline this referral after hearing and evaluating the various factors and risks involved.

I have not yet dealt with the last two paragraphs of your editorial. The implication that the young surgeon is better than the elder, is outright prejudice. Your hint that the small town physician will undermine the efforts of the "young" surgeon and your statement that the itinerant (outreach?) surgeon and the referring physician are participating in fee splitting is blatantly false, an insult to our integrity, and "cannot be condoned."

Geoffrey C Kloster, MD
President
Lincoln County Medical Society
Merrill, Wisconsin

Medical history

TO THE STATE MEDICAL SOCIETY: On behalf of the Department of the History of Medicine I would like to thank you and the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin for your support in making the volume *Wisconsin Medicine: Historical Perspectives* possible. Your assistance with both the 1976 symposium and publication of the book was crucial, and I hope you are pleased with the final product. Please pass on our appreciation to all parties involved.

Ronald L Numbers
Professor, Department
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CONTRAINDICATIONS

Quinamm may cause fetal harm when administered to a pregnant woman. Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g.) for attempted abortion. In about half of these reports the malformation was deafness related to auditory nerve hypoplasia. Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes. In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys. Quinamm is contraindicated in women who are or may become pregnant. If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus.

Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency.

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use. Recovery usually occurs following withdrawal of the medication and appropriate therapy.

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever.

WARNINGS

Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism. Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision; however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin.

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine. Quinamm should be stopped immediately if evidence of hemolysis appears.

If symptoms occur, drug should be discontinued and supportive measures instituted. In case of overdosage, see OVERDOSAGE section of prescribing information.

PRECAUTIONS

General

Quinamm should be discontinued if there is any evidence of hypersensitivity. (See CONTRAINDICATIONS.) Cutaneous flushing, pruritus, skin rashes, fever, gastric distress, dyspnea, ringing in the ears, and visual impairment are the visual expressions of hypersensitivity, particularly if only small doses of quinine have been taken. Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form. Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy.

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine. (See Drug Interactions.)

Drug Interactions

Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration. Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly.

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine.

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

The effects of neuromuscular blocking agents (particularly pancuronium, succinylcholine, and tubocurarine) may be potentiated with quinine, and result in respiratory difficulties.

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity.

Drug Laboratory Interactions

Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used.

Carcinogenesis, Mutagenesis, Impairment of Fertility

A study of quinine sulfate administered in drinking water (0.1%) to rats for periods up to 20 months showed no evidence of neoplastic changes.

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test. Intraperitoneal injections (0.5 mM/kg.) were given twice, 24 hours apart. Direct *Salmonella typhimurium* tests were negative, when mammalian liver hemogenate was added, positive results were found.

No information relating to the effect of quinine upon fertility in animal or in man has been found.

Pregnancy

Category X. See CONTRAINDICATIONS.

Nonteratogenic Effects

Because quinine crosses the placenta in humans, the potential for fetal effects is present. Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown. Quinine in toxic amounts has been associated with abortion. Whether this action is always due to direct effect on the uterus is questionable.

Nursing Mothers

Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts).

ADVERSE REACTIONS

The following adverse reactions have been reported with Quinamm in therapeutic or excessive dosage. (Individual or multiple symptoms may represent cinchonism or hypersensitivity.)

Hematologic: acute hemolysis, thrombocytopenic purpura, agranulocytosis, hypoprothrombinemia.

CNS: visual disturbances, including blurred vision with scotomata, photophobia, diplopia, diminished visual fields, and disturbed color vision; tinnitus, deafness and vertigo; headache, nausea, vomiting, fever, apprehension, restlessness, confusion, and syncope.

Dermatologic allergic: cutaneous rashes (urticarial, the most frequent type of allergic reaction, papular, or scarlatinal); pruritus; flushing of the skin; sweating; occasional edema of the face.

Respiratory: asthmatic symptoms.

Cardiovascular: anginal symptoms.

Gastrointestinal: nausea and vomiting (may be CNS-related); epigastric pain.

DRUG ABUSE AND DEPENDENCE

Tolerance, abuse, or dependence with Quinamm has not been reported.

OVERDOSAGE

See prescribing information for a discussion on symptoms and treatment of overdose.

DOSAGE AND ADMINISTRATION

1 tablet upon retiring. If needed, 2 tablets may be taken nightly—1 following the evening meal and 1 upon retiring.

After several consecutive nights in which recumbency leg cramps do not occur, Quinamm may be discontinued in order to determine whether continued therapy is needed.

Product Information as of October 1980

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial pr tions, prolonged use may result in overgrowth o susceptible organisms, including fungi. Appro measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a nc common cutaneous sensitizer. Articles in the cu literature indicate an increase in the prevale persons allergic to neomycin. Ototoxicity and n toxicity have been reported (see Warning section

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ICATION. For the relief of mild-to-moderate pain
NTRAINDICATION. Hypersensitivity to propoxene or to acetaminophen
RNINGS: CNS ADDITIVE EFFECTS AND OVERSAGE Propoxyphene in combination with alcohol quilizers sedative-hypnotics, or other CNS dessants has an additive depressant effect Pats taking this drug should be advised of the additive ct and warned not to exceed the dosage recomnded Toxic effects and fatalities have occurred owing overdoses of propoxyphene alone or in nbination with other CNS depressants Most of se patients had histories of emotional disturbes or suicidal ideation or attempts as well as use of tranquilizers alcohol, or other CNS-active gs Caution should be exercised in prescribing e amounts of propoxyphene for such patients e **Management of Overdosage**)
UG DEPENDENCE: Propoxyphene can produce g dependence characterized by psychic dependee and less frequently physical dependence and rance It will only partially suppress the withwal syndrome in individuals physically dependent morphine or other narcotics The abuse liability of poxyphene is qualitatively similar to codeine s aligh quantitatively less and propoxyphene should prescribed with the same degree of caution appnate to the use of codeine
AGE IN AMBULATORY PATIENTS. Propoxyne may impair the mental and/or physical abilities uired for potentially hazardous tasks e g driving ar or operating machinery Patients should be tioned accordingly
AGE IN PREGNANCY. Safe use in pregnancy not been established relative to possible ase effects on fetal development INSTANCES OF THDRAWAL SYMPTOMS IN THE NEONATE VE BEEN REPORTED FOLLOWING USAGE RING PREGNANCY Therefore propoxyphene uld not be used in pregnant women unless in the judgement of the physician, the potential benefits outweigh the possible hazards
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group
PRECAUTIONS: Confusion, anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness sedation nausea and vomiting These seem more prominent in ambulatory than in nonambulatory patients some of these reactions may be alleviated if the patient lies down
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness headache weakness euphoria dysphoria and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**)
Confusion anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine
MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma pupillary constriction, and circulatory collapse In addition to these characteristics which are reversed by narcotic antagonists such as naloxone, there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting anorexia and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill, however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity, jaundice coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists, naloxone nalorphine and levallorphan are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered preferably I V , simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions
Oxygen, IV fluids vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia nausea vomiting and drowsiness Appropriate literature should be consulted for further information (JAMA 237 2406-2407 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

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(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

*__INDICATIONS__: Based on a review of this drug by the National Academy of Sciences—National Research Council and or other information FDA has classified the indications as follows
"Possibly" effective for the treatment of pain accompanied by tension and or anxiety in patients with musculoskeletal disease or tension headache
Final classification of the less-than-effective indications requires further investigation
The effectiveness of Equagesic in long-term use, i e more than four months, has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin meprobamate, or ethoheptazine citrate
WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination
USAGE IN PREGNANCY AND LACTATION An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered
Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under
PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery
Suicidal attempts with meprobamate have resulted in coma shock vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure pulse and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants e g , caffeine Metrazol or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels
ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or methylphenidate sulfate concomitantly to control drowsiness
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions
Mild reactions are characterized by an itchy urticanal or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae ecchymoses, peripheral edema and fever have also been reported
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, m of these returned to normal without discontinuation of t drug
Impairment of accommodation and visual acuity has be reported rarely
OVERDOSE: Two instances of accidental or intentional s nificant overdosage with ethoheptazine citrate combined w aspirin have been reported These were accompanied symptoms of CNS depression, including drowsiness and lig headedness, with uneventful recovery However, on the ba of pharmacological data, it may be anticipated that CNS sti ulation could occur Other anticipated symptoms would clude nausea and vomiting Appropriate therapy of signs a symptoms as they appear is the only recommendation po sible at this time Overdosage with ethoheptazine combin with aspirin would probably produce the usual symptoms a signs of salicylate intoxication Observation and treatme should include induced vomiting or gastric lavage, speci parenteral electrolyte therapy for ketoacidosis and dehydr tion, watching for evidence of hemorrhagic manifestatio due to hypoprothrombinemia which, if it occurs, usually quires whole-blood transfusions
DESCRIPTION Each Equagesic tablet contains 150 mg m probamate 75 mg ethoheptazine citrate and 250 mg aspir

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*This drug has been evaluated as possibly effective for this indication

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Obituaries

✓County, State, and AMA members

✓**George J Pugh, MD,** 83, formerly of Racine, died May 1, 1981 in Punta Gorda, Fla. Born Aug 7, 1897 in Racine, Doctor Pugh graduated from Marquette University School of Medicine in 1922 and served his internship at Receiving Hospital, Detroit, Mich. Doctor Pugh had practiced medicine in Racine from 1924 until his retirement in 1971. He became a member of "50 Year Club" of the State Medical Society of Wisconsin in 1972. Surviving is his widow, Alice, of Punta Gorda, Fla.

✓**Russell G Strong, MD,** 79, Manitowoc, died June 23, 1981 in Manitowoc. Born Oct 31, 1901 in Milwaukee, Doctor Strong graduated from Loyola University School of Medicine, Chicago, in 1932 and served his internship at Mercy Hospital in Chicago. Doctor Strong began his medical practice in Manitowoc in 1933 and served as health commissioner, medical director of Family Heritage Nursing Home and Manitowoc County Hospital, and served as chief-of-staff of Memorial Hospital. He also was a past president of Manitowoc County Medical Society. Doctor Strong had been active in many affairs of the community and served on numerous committees. Surviving are his widow, Anne; and a son, Russell of Santa Barbara, Calif.

✓**Bruce C Prentice, MD,** 60, Mellen, died July 8, 1981 in Ashland. Born Nov 25, 1920 in Minneapolis, Minn, Doctor Prentice graduated from the University of Minnesota School of Medicine in 1951 and served his internship at St Mary's Hospital in Minnesota. After 25 years of general practice and surgery, Doctor Prentice returned to the University of Minnesota and completed a fellowship in anesthesiology and worked in that specialty until his death. In 1974 he was awarded the "Max Fox Preceptor Award" from the University of Wisconsin Medical School. In addition to his profession, Doctor Prentice was actively involved in establishing the "Save Lake Superior Association," the Superior National Park, the Sylvania Wilderness Area, and was a pioneer in many other environmental issues. Surviving are his widow, Lorraine; two sons, Bruce and John, Ashland; and two daughters, Mrs Donald (Jo Ann) Zifko and Mrs Hank (Susan) Martinsen, both of Ashland.

Alexander S Hartman, MD, 73, Milwaukee, died July 9, 1981, in Milwaukee. Born Feb 14, 1908 in Russia, Doctor Hartman graduated from Loyola University School of Medicine, Chicago, in 1931 and served his internship at St Bernard Hospital, Chicago. During World War I, Doctor Hartman served in the United States Army Medical Corps. He was on the medical staff of Wood Veterans Administration Hospital until his retirement. Surviving are his widow, Irene, and a daughter, Nancy.

✓**Clarence H Boren, MD,** 88, Marinette, died July 12, 1981 in Marinette. Born Oct 28, 1892 in Marinette, Doctor Boren graduated from Northwestern University Medical School in 1917 and served his internship at Michael Reese Hospital in Chicago. He served with the United States Army Medical Corps during World War I and also took post-graduate work at Vienna University. Doctor Boren served as president of the Marinette-Florence County Medical Society and also was a member of the "50 Year Club" of the State Medical Society of Wisconsin. Active in community affairs, Doctor Boren was named "Man of the Year" by the Marinette Area Chamber of Commerce in 1966. Surviving are his widow, Gertrude; one daughter, Mrs Jean Hallett; two sons, Dr Clark and Dr James of Marinette.

Joseph P Skibba, MD, 76, Kaukauna, died July 14, 1981 in Marshfield. Born Feb 22, 1905 in Antigo, Doctor Skibba graduated from Marquette University School of Medicine in 1931 and completed his internship at St Elizabeth in Appleton. His residency was served at Milwaukee County Hospital. He served in the United States Navy for two years, had practiced in Kaukauna and most recently was a member of the medical staff of Veterans Home in Iron Mountain, Mich. Surviving are his widow, Carol; four daughters, Mary Keup, Costa Mesa, Calif; Sue, San Diego, Calif; Carol Daniel, Janesville; Catherine Smith, New Zealand; and four sons, Paul, Mequon; Joseph, Greendale; Richard, Wichita, Kan; and John of Little Chute.

Elaine Kohler, MD, 42, Milwaukee pediatrician and an associate professor of pediatrics at the Medical College of Wisconsin, died Aug 2, 1981 in a plane crash with her husband, James B Hewitt. Born Feb 5, 1939 in Paris, France, Doctor Kohler graduated from Boston University School of medicine and served her internship and residency at Milwaukee Children's Hospital. She was on the medical staff at Milwaukee Children's Hospital and also served as president of the Milwaukee Pediatrics Society. In 1975 she was president of the Wisconsin Chapter, American Diabetes Association. Surviving is her mother, Mrs David Humphreys of Dorset, Vt. ■

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Membership Directory UPDATE

Prepared from the July 14, 1981 Membership Report and from member notifications to Wisconsin Medical Journal for updating the 1980-81 Membership Directory published in the January 1981 issue.

Physicians are reminded that the newly revised Constitution and Bylaws, as adopted by the 1981 House of Delegates and printed in the June 1981 *Blue Book* issue, state that "any member whose current year's dues have not been received by the secretary of this Society by May 15 shall be deemed in arrears and his name shall be removed from the membership rolls of his county society and this Society until such time as full dues for the current year have been received." Reelected members are those physicians who previously were members. Reinstated members are those physicians removed from membership who have been returned to the roster without a break in membership.

ASHLAND-BAYFIELD-IRON

Reinstated members

GS OPH
Doty, John W
1001 2nd St W
Ashland WI 54806
(715) 682-4515

BROWN

Reinstated members

GS TS
Beno, Thomas J
1751 Deckner Ave
Green Bay WI 54302
(414) 468-5621

IM HEM
Lacey, James V
1821 S Webster Ave
Green Bay WI 54301
(414) 435-4341

DANE

New members

FP
Bernardoni, Robert J
6497 Whalen Rd
Verona WI 53593

PDC CD
Corliss, Robert J
707 S Mills St
Madison WI 53715

AN
Hellman, Daniel R
5305 Manitowoc Parkway
Madison WI 53705

PA
Hokin, Lowell E
5 Nokomis Ct
Madison WI 53711

FP
McHenry, Michael G
213 Parkview Lane
Verona WI 53593

IM
Taylor, Benton C
3906 Priscilla Lane
Madison WI 53705

OTO
Wolter, Robert K
ENT Dept UW CSC
600 Highland Ave
Madison WI 53792

Address changes

New	*Old*
AN **Behrens, Scott A** 459 Emerson Neenah WI 54956	4115 Meyer Ave Madison WI 53711

DANE continued

AN **Boncyk, John C** 831 Bradley Ave Eau Claire WI 54701	Eau Claire WI 53562
P **Godfrey, Charles B** 4828 Emerson Ave South Minneapolis MN 55409	1226 Milton St Madison WI 53715
OPH **Gonnering, Russell S** 11645 Diane Dr Wauwatosa WI 53226	7433 Old Sauk Rd Madison WI 53717
OTO **Harrison, James E** 3019 Kingston Way Dubuque IA 52001	7023 Parkshore Court Middleton WI 53562
IM **Liebow, Mark F** 626 Church St Evanston IL 60201	1431 Morrison St Madison WI 53703
R **Liebel, Steven S** 3932 Cumming Ave Eau Claire WI 54701	5326 Milward Dr Madison WI 53711
PTH **Lloyd, Ricardo V** 1335 E Catherine St Box MO45 Ann Arbor MI 48109	430 E 67th St Apt 9M New York NY 10021
OTO **Miller, Gary T** 1119 E Wakeman Wheaton IL 60187	62 Hollywood Dr Madison WI 53713
ORS **Worsing Jr, Robert A** 3244 East Douglas Wichita KS 67208	3409 Roma Lane Middleton WI 53562

DOUGLAS

Reinstated members

R
Mann, Robert
515 Third Ave East
Superior WI 54880

EAU CLAIRE-DUNN-PEPIN

Reinstated members

GP
Hanley, Larry L
347 Prairie View Rd
Chippewa Falls WI 54729

JEFFERSON

Removed from membership

Tonn, Elizabeth C

LINCOLN

Address changes

New	*Old*
IM ON **Valcarcel, Jorge A** 1635 3rd Ave Chula Vista CA 92011	716 E 2nd St Merrill WI 54452

MANITOWOC

Removed from membership

Pick, Daniel M

MARATHON

New members

AN
Doan, Nam Dinh
1612 Foothill Ave
Schofield WI 54476

Address changes

New	*Old*
N PD **Lee, Yu-en** 44855 N 10th St, W Lancaster CA 93534	425 Pine Ridge Blvd Wausau WI 54401

MILWAUKEE

New members

EM
Bartlett, J Michael
11130 W Morgan K-211
Greenfield WI 53228

1M
Braunstein, William I
2923 N 75th St
Milwaukee WI 53210

OPH
Davenport, Richard D
2400 S 90th St
West Allis WI 53227

GS FP
Diktas, Mustafa K
5148 N Teutonia Ave
Milwaukee WI 53209

P
Kaunas, Roman R
2303 N 39th St
Milwaukee WI 53210

AN
Kim, Joseph M
9997 W Greenwood Terr
Milwaukee WI 53224

OPH
Kwasny, Gregory P
2300 N Mayfair Rd
Milwaukee WI 53226

FP
Lillich, David W
720 E Beaumont
Whitefish Bay WI 53217

OS U
Tofani, Walter O
500 N 19th St
Milwaukee WI 53233

Reinstated members

P
Bogost, Bruce R
W303 N5965 Sehler's Ln
Hartland WI 53029

GP GS
Bonan, Joseph D
10425 W North Ave
Wauwatosa WI 53226

MILWAUKEE continued

FP
Devitt, Joseph S
2315 North Lake Dr
Milwaukee WI 53211

OTO
Finn, Charles J
10520 N P Washington Rd
Mequon WI 53092

1M
Fricano, Salvatore
3201 South 16th St
Milwaukee WI 53215

OTO PS
Gogan, Robert J
10520 N P Washington Rd
Mequon WI 53092

ORS
Guhl, James F
5757 W Oklahoma Ave
Milwaukee WI 53219

OTO
Horwitz, S Fredric
10520 N P Washington Rd
Mequon WI 53092

GP
Kah, William W
7712 W Burleigh St
Milwaukee WI 53222

OTO
Noonan, Patrick J
10520 N P Washington Rd
Mequon WI 53092

1M
Nuyda, D'Jahlma A
5854 S Packard Ave
Cudahy WI 53110

AN
Phillips, Wilson S
6167 N Berkeley Blvd
Milwaukee WI 53217

AN
Schmidt, James R
2825 N Mayfair Rd
Milwaukee WI 53222

DR
Smullen, William A
Dept of Radiology
5000 W Chambers St
Milwaukee WI 53210

1M NEP
Stolp, Sherwood B
3201 S 16th St
Milwaukee WI 53215

Reelected members

CVS GS
Kiselow, Mark C
2300 N Mayfair Rd, #755
Milwaukee WI 53226

Address changes

New	*Old*
NS N **Berglund, George A** 3070 N 51st St, #601 Milwaukee WI 53210	3070 N 51st St
GS RET **Craite, Edgar J** 301 West Marion St Portage WI 53901	319 Annette Ct Rhinelander WI 54501
OPH **Davis, Jeffrey P** 2351 Clay St, #414 San Francisco CA 94115	13000 W North Ave Brookfield WI 53005
PD NEP **Eisenberg, Carl S** 3003 W Good Hope Rd PO Box 17300 Milwaukee WI 53217	Milwaukee WI 53209
FP **Hollenbeck, Stanley W** 11957 W Appleton Ave Milwaukee WI 53224	6001 W Center St Milwaukee WI 53210

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NS
Ullrich, Donald P
3070 N 51st St, #601
Milwaukee WI 53210

3070 N 51st St
Milwaukee WI 53210

GS
Yunus, Hafiz M
2040 W Wisconsin Ave, #681
Milwaukee WI 53233

1004 N 10th St
Milwaukee WI 53233

ONEIDA-VILAS

New members

GP
Kretz, Michael J
Eagle River WI 54521

Reinstated members

GP
Schell, Charles A
PO Box 549
Woodruff WI 54568

IM
Schwartz, Henry J
PO Box 549
Woodruff WI 54568

OUTAGAMIE

Address changes

New — *Old*

R ON
Larkin, Dixon F
3469 Terrace View Dr
Salt Lake City UT 84109

1416 S Fidelis St
Appleton WI 54911

Reinstated members

GS
Bonner, Joseph N
106 River Dr
Appleton WI 54911

OZAUKEE

Reinstated members

FP
Pfeffer, Robert A
118 E Grand Ave
Port Washington WI 53074

PRICE-TAYLOR

Reinstated members

IM
Frederick, T Bayard
789 S 7th Ave
Park Falls WI 54552

RACINE

Address changes

New — *Old*

OBG
Miller Jr, Donald W
477 Windridge Dr
Racine WI 53402

2405 Northwestern Ave
Racine WI 53404

SAUK

Address changes

FP
Moede, James G
2510 Grandview Rd
Fond du Lac WI 54935

PO Box 502
Waupaca WI 54981

Deceased members

Booher, John A—June 17, 1981

SHAWANO

New members

FP
Jeffries, Richard D
504 Weed St
Shawano WI 54166

SHEBOYGAN

New members

FP
Northup, Cynthia P
434 Erie Ave
Sheboygan WI 53081

WALWORTH

New members

GS ON
Seldera, Juanilito N
Fontana WI 53125

WASHINGTON

New members

ORS
Schneider, Paul R
1201 Oak St
West Bend WI 53095

WAUKESHA

Address changes

New — *Old*

PTH
Rykwalder, Paul J
15000 W North Ave
Brookfield WI 53005

PO Box 427
Menomonee Falls WI 53051

Reinstated members

FP
Clothier Jr, W J Kilburn
413 N East Ave
Waukesha WI 53186

WINNEBAGO

Address changes

New — *Old*

AN
Barbour, James H
1322 Menominee Dr
Oshkosh WI 54901

PO Box 305
Green Lake WI 54941

WOOD

Address changes

New — *Old*

IM
Ries, Peter M
1137 Briarwood
Marshfield WI 54449

621 North Plum Ave ■

Blue Book–Update

The SMS Board of Directors on July 18, 1981 confirmed the following appointments of physicians to Commissions and Committees.

In the listing on page 72 of the June 1981 **Blue Book** under section representatives of the Commission on Governmental Affairs the following changes should be made:

Physical Medicine and Rehabilitation:. *Neal Taylor, MD,* LaCrosse
Pathology: *Harry J Zemel, MD,* Fond du Lac
Surgery: *George F Flynn, MD,* Milwaukee

On page 72 under the Commission on Continuing Medical Education, Franke E Berridge, MD, Milwaukee, and Joseph J Mazza, MD, Marshfield should be added.

On page 74 under the Commission on Public Information, Carl R Poley, MD, Green Bay, should be included.

On page 76, under the Committee on Women Physicians, include Janet C Lindemann, MD, Waukesha and on page 75, under the Committee on Alcoholism and Other Drug Abuse, Herbert C White, DO, Genesee Depot, should be added. ■

"WATS" LINE FOR MEMBERS

As a service for its members, the State Medical Society of Wisconsin has a **toll-free** WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

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Specialty Societies

*Physician members of State Medical Society of Wisconsin

American Society for Gastrointestinal Endoscopy has announced the election of Joseph E Geenen, MD,* Milwaukee, as president-elect of the ASGE. Doctor Geenen, clinical professor of medicine at the Medical College of Wisconsin, served as the society's treasurer from 1977 to 1981. He is director of the Digestive Disease Center at St Luke's Hospital in Racine and is known for his research and treatment of diseases of the pancreas and biliary system.

DOCTOR GEENEN

American College of Radiology (ACR) will honor four Milwaukee-area physicians for their special contributions to the medical profession during the annual meeting of the ACR in Las Vegas September 21-25. They are: Daniel J Price, MD* Fox Point; Alan B Fidler, MD,* East Troy; Timothy T Flaherty, MD,* Neenah; and Jerome L Marks, MD,* Carlsbad, California (previously a resident of Milwaukee). These radiologists were selected for Fellowship in the ACR, a professional medical society representing 18,000 physicians. Doctor Price, a native of Milwaukee and a 1949 graduate of the Medical College of Wisconsin, is affiliated with St Michael's Hospital. Doctor Fidler, a native of West Allis, is a 1946 graduate of the University of Wisconsin. He is affiliated with St Luke's, St Francis', and St Mary's hospitals, Milwaukee; Trinity Memorial Hospital, Cudahy; and St Luke's Memorial Hospital and St Mary's Medical Center, Racine. Doctor Flaherty, born in Fond du Lac and a 1959 graduate of Marquette University School of Medicine, is affiliated with Theda Clark Regional Medical Center, Neenah; Mercy Medical Center, Oshkosh; and Riverside Community Memorial Hospital, Waupaca. Doctor Marks, a native of Milwaukee, is a 1938 graduate of Marquette University School of Medicine. He is affiliated with Milwaukee County General, Lutheran, and Family hospitals, Milwaukee.

American Association of Contemporary Medicine and Surgery recently promoted Francis Gilbert, MD,* Kewaunee, to the status of a Fellow in the Association. Doctor Gilbert received a similar Fellowship in the American College of Obstetrics and Gynecology in 1963 which was awarded to him four years after his completion of a three-year specialty training course which he received while he was a member of the United States Navy. ■

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Physician Briefs

*Physician members of State Medical Society of Wisconsin

Barry Rogers, MD, Green Lake, has joined Berlin Surgical Service Corporation in the Physicians Clinic. He is associated with Michael E Tieman, MD* and the Berlin Memorial Hospital. Doctor Rogers graduated from Emory University Medical School and completed his residency in general surgery at Grady Hospital in Atlanta, Ga.

David J Lofgren, MD, Horicon, recently joined the medical staff of the Flyway Medical Clinic. A University of Minnesota School of Medicine graduate, Doctor Lofgren completed his family practice residency in Cedar Rapids, Iowa. He is on the medical staff of Hillside Community Hospital.

John J Kief, MD,* Rhinelander, recently was elected president of the Wisconsin Professional Review Organization (WisPRO) at its Annual Meeting. He will serve as president for 1981-82 term. Doctor Kief is associated with the Bump Medical Group and is a member of the medical staff of St Mary Hospital in Rhinelander. He also is on the Board of Directors of the State Medical Society.

DOCTOR KIEF

Richard L Ellis, MD*, Middleton, has become associated with the Quisling Clinic medical staff. A pediatrician, Doctor Ellis graduated from Rush Medical College, served his internship at St Luke's Medical Center in Chicago, and his residency was completed at the University of Michigan.

Tom J McCool, MD, Oshkosh, recently joined the medical staff of the Oshkosh Clinic. Doctor McCool graduated from the University of Iowa College of Medicine and completed a three-year family practice residency in Des Moines.

Peter Hamel, MD, Waupaca, recently joined the medical staff of Riverside Hospital in Waupaca. Doctor Hamel graduated from the University of Wisconsin Medical School, Madison, and completed his residency at the University Medical Center, Columbia, Mo. A pathologist, Doctor Hamel also completed a year of study at St Luke's Hospital in Milwaukee.

James D Fogleman, MD, Dallas, Tex, recently was named associate director of Waukesha Memorial Hospital's Family Practice Residency Program. Doctor Fogleman graduated from Southwestern Medical School, Dallas, Tex, was in private medical practice in Dallas, and served in the United States Air Force for two years. Prior to being named associate director of Waukesha's Family Practice Residency Program, Doctor Fogleman was an associate professor in the Department of Family Practice and Community Medicine at the University of Texas Health Science Center at Dallas, Southwestern Medical School, and director of the St Paul Hospital/ Southwestern Medical School Family Practice Residency Program also at Dallas.

Marshall E Cusic Jr, MD recently was appointed to the medical staff of Jackson Clinic in Madison. He will serve in the allergy department. Doctor Cusic graduated from the Medical College of Wisconsin, Milwaukee, and completed his residency in Ohio and Wisconsin. He was on the faculty at the Medical College of Wisconsin and also at the University of California, San Diego.

D King Aymond, MD has joined the Sheboygan Clinic's Department of Ophthalmology associated with Edward G Schott, MD.* Doctor Aymond graduated from the University of Texas Medical School at Houston and served his internship and residency at University of Texas Medical Branch in Galveston.

Rieck W Beiersdorf, MD has joined the Sheboygan Clinic's medical staff. He graduated from the University of Wisconsin Medical School and served his family practice residency at St Luke's Hospital in Milwaukee. He also served on the medical staff of United Church of Christ Mission Hospital in Ghana, Africa.

Chung M Lee, MD, has joined the Department of Radiology at the Marshfield Clinic. Doctor Lee graduated from Seoul National University School of Medicine in Korea. Following service as a medical officer in the Korean Air Force, Doctor Lee came to the United States and served an internship at Graduate Hospital at the University of Pennsylvania. He then completed his residency at Emory University in Atlanta, Ga. Prior to joining the medical staff of the Marshfield Clinic, Doctor Lee was on the staff of the Massachusetts Eye and Ear Infirmary in Boston.

Andrea Dlesk, MD, recently became associated with the medical staff of the Marshfield Clinic in the Department of Medicine, Rheumatology Section. Doctor Dlesk graduated from Harvard Medical School and served her internship and residency at the University of Wisconsin Hospital & Clinics in Madison. She also served a fellowship in rheumatology and clinical immunology at the University of Florida College of Medicine in Gainesville.

Kenneth Kidd, MD, Whitewater, recently joined the Whitewater Family Practice Clinic. Doctor Kidd graduated from Rush Medical College in Chicago, and completed his residency at the Bowman Gray School of Medicine at Wake Forest University, Winston-Salem, NC.

Muhammad Y Ahmad, MD,* Merrill, recently was elected a fellow of the International College of Surgeons. Doctor Ahmad will receive the diploma at the Annual Meeting which will be held in Coronado, Calif, in November. He is associated with the Merrill Medical Associates, SC, in Merrill.

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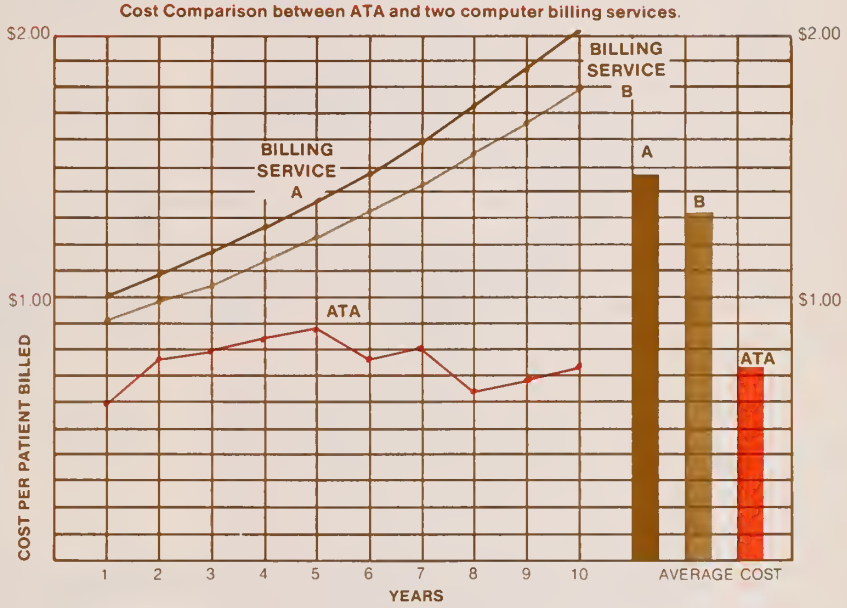

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FWT-24 C-E-L

James C Turner, MD, Hartford, recently joined the multispecialty group of Parkview Medical Associates, Ltd, Hartford, Wis. Doctor Turner graduated from the University of Wisconsin Medical School, Madison, and completed his residency in internal medicine at the University of Virginia, Charlottesville. Prior to joining Parkview Medical Associates, Ltd, he spent two years at the Fort Defiance Indiana Hospital, Fort Defiance, Ariz.

Margaret Block, MD, recently became associated with The Monroe Clinic. Doctor Block graduated from Albany Medical College in New York in 1976 and interned at Rush-Presbyterian-St Luke's Hospital in Chicago. Doctor Block also completed a fellowship in medical oncology at the University of Wisconsin Clinical Cancer Center in Madison.

Jeffrey J Carroll, MD, Berlin, recently became associated with the Berlin Medical Associates Clinic. He joins MDs Alonzo R Gimenez,* David J Sievers,* and Steve R Osicka* in the clinic. He graduated from The Medical College of Wisconsin, Milwaukee, completed his internship at Cleveland Clinic, and his residency at The Medical College of Wisconsin affiliated hospitals in Milwaukee.

William D Moore, MD, Stevens Point, recently joined the medical staff of the Rice Clinic. An orthopedic surgeon, Doctor Moore graduated from Northwestern University Medical School, Evanston, Ill, in 1976 and completed his residency at Akron City Hospital in Ohio.

Edwin D Fischer, MD, formerly of Madison, recently began his medical practice in Lake Mills. A native of Port Edwards, Doctor Fischer graduated from the University of Wisconsin Medical School, Madison, in 1978 where he also completed his family practice residency.

Sarah J Pratt, MD has joined the Sheboygan Clinic's Department of Pediatrics. She will be associated with MDs G Mohammad,* D Douglas Opel,* John M Reinemann,* and Rolf L Simonson.* Doctor Pratt graduated from the Medical College of Wisconsin and served her residency at Milwaukee Children's Hospital. She is married to Dean Pratt, MD* who is with the Clinic's Department of Surgery.

Kwan Cho, MD, LaCrosse, recently became a member of the medical staff of St Francis Medical Center, Doctor Cho graduated from Seoul National University and served in the Korean navy for three years as a medical officer. He served his residency in anesthesiology at Long Island College Hospital in New York City, and after his residency, he had a fellowship at the Cleveland Clinic, Ohio.

Michael J Moran, MD, Sheboygan, has become associated with Christopher A Graf, MD* in Sheboygan. Doctor Moran graduated from Rush Medical College, Chicago, and served an internship at Duke University Medical Center, Durham, NC. He completed residencies at Loyola University Medical Center, Maywood, Ill; Hines Veterans Administration Hospital, Hines, Ill; and at Children's Memorial Hospital.

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Daniel J McCarty, MD, professor and chairman, Department of Medicine at the Medical College of Wisconsin (MCW), Milwaukee, was awarded the Geigy Rheumatism First Prize in Paris, France, as part of the opening ceremony of the Fifteenth International Rheumatism Congress June 21. Doctor McCarty was cited for his ongoing research, begun in the early 1960s, clarifying the role of microcrystals in gout, pseudogout, and the "Milwaukee Shoulder Syndrome." Doctor McCarty discovered pseudogout 20 years ago while working in Philadelphia. He discovered the "Milwaukee Shoulder Syndrome" last year at MCW. In accepting the award, Doctor McCarty stated, "Much credit goes to the talented team of MCW investigators working at Milwaukee County Medical Complex; especially Herman S Cheung, PhD (biochemist); Paul S Halverson, MD and John C Garancis, MD (electron microscopists); David Palmer, PhD (physicist); Lawrence Ryan, MD and Franklin Kozin, MD (metabolic specialists); Bruce J Brewer, MD* (orthopedist); William Carrera, MD (skeletal radiologist); Neil and Gretchen Mandel, PhDs (crystallographers). "The array of skills represented by this group is truly extraordinary and will serve as the nucleus for the Arthritis Research Institute at MCW presently being planned by us," Doctor McCarty noted.

DOCTOR McCARTY

Daniel Fary, MD, Fort Atkinson, recently opened his office for the practice of ophthalmology. He graduated from Purdue University and completed his residency at the University of Indiana School of Medicine. Prior to moving to Fort Atkinson, Doctor Fary had been in private practice in Beaver Dam.

James C Turner, MD, Hartford, recently became a member of the Parkview Medical Associates, Ltd. Doctor Turner graduated from the University of Wisconsin Medical School, Madison, and completed his internal medicine residency at the University of Virginia Hospital in Charlottesville, Va. He has spent the last two years in medical practice with the Indian Health Service stationed at Fort Defiance located in northeastern Arizona on the Navajo Reservation.

Kenneth Wallmeyer, MD, Owen, recently became associated with William Hopkins, MD* at the Owen-Withee Family Clinic. Doctor Wallmeyer graduated from the Medical College of Wisconsin, Milwaukee, and completed his residency in internal medicine at the Erie County Medical Center in Buffalo, New York.

Peter N Dahlie, MD, Phillips, recently became associated with the Lakeland Medical Associates, Ltd, in its Phillips Clinic. He graduated from the University of Wisconsin Medical School, Madison, and completed his residency at St Joseph's Hospital in Flint, Mich.

Henry M Wilson, MD,* Madison internist with the Jackson Clinic, currently certified by the Federal Aviation Administration as an aviation medical examiner and accident investigator, has now been further certified as a senior aviation medical examiner authorizing him to conduct first class FAA required physical examinations for professional airline pilots. Doctor Wilson, who is board certified in internal medicine and a licensed pilot, will continue to conduct required flight physicals for all private and commercial pilots.

Carrie Nelson, MD, recently became associated with Frank A Springer, MD* in Elmwood. Doctor Nelson graduated from the University of Minnesota School of Medicine and completed her residency program at the University of Minnesota Hospitals. Prior to joining Doctor Springer, she had been a member of the medical staff of the Veterans Administration Hospital in Minneapolis.

Frank W Kilpatrick, MD recently was appointed to the medical staff of Jackson Clinic in Madison. A specialist in rheumatology, Doctor Kilpatrick graduated from the University of Vermont Medical School and completed his residency at North Carolina Memorial Hospital in Chapel Hill. He also was a fellow in rheumatology and adjunct assistant professor of medicine at Dartmouth Medical School, Hanover, NH.

Steven Rosebrock, MD, who has been in private medical practice in Clarinda, Iowa, recently joined the staff of Appleton's Fox Valley Family Practice Residency Clinic as associate director. Doctor Rosebrock graduated from Northwestern University Medical School and served his residency at the University of Nebraska. He is the second full-time physician to be added to the staff at the clinic which gives medical school graduates comprehensive three-year training in family practice. Charles E Fenlon, MD* is the director of the clinic and was instrumental in getting the family practice residency program for Appleton.

Lawrence J Litscher, MD, recently became associated with The Burlington Clinic. Doctor Litscher graduated from the University of Iowa Medical School and completed his residency in urology at the Medical College of Wisconsin in Milwaukee.

Alexandra T Sosenko, MD, has joined the Department of Family Practice at The Burlington Clinic. Doctor Sosenko graduated from the Medical College of Wisconsin and completed her residency at Deaconess Hospital in Milwaukee.

Mark Bixby, MD, recently joined the Department of Family Practice at the Grantsburg Clinic, Ltd. He graduated from the Abraham Lincoln School of Medicine, University of Illinois, Chicago, and completed his residency at the University of Minnesota, North Memorial Center, Minneapolis. He is a diplomate of the American Board of Medical Examiners and a member of the American Academy of Family Physicians. Doctor Bixby also is a member of the medical staff of Burnett General Hospital.

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Methodist Hospital, Madison, and its medical staff are sponsoring "A Town Hall Meeting on Health Care Costs" on Wednesday, October 21 at the Madison Civic Center with distinguished Stanford University economist Alain C Enthoven, PhD, as special guest speaker.

The afternoon session from 2 to 4 PM is open to the general public free of charge. The program will focus on "Health Care Costs in the 80s—You *Do* Have a Choice." A reactor panel of providers, employers, legislators, and consumers will respond to Enthoven's presentation.

An evening session will be held from 7:30 to 9:30 PM for health care providers, members of the business community, and the general public. There is a $7.50 fee for the evening program. It will investigate "The Impact of Reaganomics on the Health Care Delivery System: A Providers'/Employers' Perspective." Again a reactor panel of providers, business people, employers, and legislators will comment on Enthoven's presentation.

Doctor Enthoven is the author of a book which analyzes the increases in health care costs and proposes a comprehensive health care plan that lowers costs while improving the quality of care.

He has served as an advisor to both the Carter and Reagan administrations and was the assistant secretary of defense under former secretary Robert McNamara. Doctor Enthoven is the Marriner S Eccles Professor of public and private management in the Graduate School of Business at Stanford University, a member of the Institute of Medicine of the National Academy of Science and the former president of the Litton Medical Products.

Three bills have been introduced into Congress based on the principles of Doctor Enthoven's health care plan. They are: the Health Cost Restraint Act of 1979, the Health Incentives Reform Act (Summer 1979) and the Comprehensive Reform Act (July 1979).

For more information contact Methodist Hospital, Community Relations department at (608) 251-2371, or see further details in an ad elsewhere in this issue.

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Medical College of Wisconsin, Milwaukee, has announced the appointment of Richard J Lesnaik, director of development and an administrative officer. Mr Lesniak's development experience in the healthcare field includes eight years at Northwestern University directing at varying times corporate support, alumni giving, and $55 million campaign for the medical campus, which included the University's medical school, dental school, and affiliated hospital. His most recent appointment was executive director of development at Sacred Heart School of Theology in Hales Corners.

St Joseph's Hospital, Chippewa, recently reelected Warren K Wright, MD* president of the medical staff. Doctor Wright has been chief pathologist at the hospital since 1971 and is the director of laboratory medicine. He also is chairman of the Department of Pathology and Continuing Medical Education Committee. Reelected vice president and secretary-treasurer were Reynaldo C Maniquiz, MD,* Mahmoud S Taman, MD* of Chippewa Falls, respectively. Doctor Maniquiz is chairman of the Department of Medicine and Doctor Taman is medical director of the hospital's psychiatric day treatment program.

Medical College of Wisconsin, Milwaukee, recently announced the appointment of Jose B Torres, PhD assistant professor of psychiatry and mental health sciences, to assistant dean of student affairs and director of the office of minority affairs at MCW. In addition to his new duties, Doctor Torres will continue on a part-time basis his teaching activities at MCW and provide counselling to individuals, couples, and families at the Milwaukee County Health Center. Doctor Torres received his doctorate degree in urban education with special emphasis in educational psychology from the University of Wisconsin, Milwaukee. He is a member of the American Association for Marriage and Family Therapy, Wisconsin Association for Marriage and Family Therapy, the National Association of Social Workers, the American Personnel and Guidance Association, and the American Association of Orthopsychiatry.

United States Pharmacopeial Convention (USP) has named Richard I H Wang, MD, PhD of Milwaukee to serve on its Expert Advisory Panel on Neurological and Psychiatric Disease. This USP Panel is one of 26 expert advisory panels which provide input into the publications of the USP Drug Information Division. In addition, the advisory panel provides advice to the USP Committee of Revision for the development of the official standards of strength, quality, purity, packaging, and labeling. During its 1980-1985 term, the Panel will develop, review, and revise drug monographs for the annual editions of *USP Dispensing Information (USP DI)* and *About Your Medcines,* a new, lay language drug-use handbook. Panel members also will be involved in the continuing drug education and information programs of USP, including development of the bimonthly Updates to *USP DI,* a new consumer "About Your Medicines" newsletter, and a series of weekly newspaper columns. Doctor Wang is Chief, Clinical Pharmacology, The Medical College of Wisconsin, Wood Veterans Administration Hospital, Milwaukee. ■

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Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema, and bronchospastic reactivity to aspirin, iodides, or other nonsteroidal anti-inflammatory agents. Anaphylactoid reactions have occurred in such patients.

Warnings: Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. *Motrin* should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If *Motrin* must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Chronic studies in rats and monkeys have shown mild renal toxicity characterized by papillary edema and necrosis. Renal papillary necrosis has rarely been shown in humans treated with *Motrin*.

Precautions: Blurred and/or diminished vision. scotomata, and/or changes in color vision have been reported. If these develop, discontinue *Motrin* and the patient should have an ophthalmologic examination, including central visual fields and color vision testing. **Fluid retention and edema** have been associated with *Motrin;* use with caution in patients with a history of cardiac decompensation or hypertension. *Motrin* is excreted mainly by the kidneys. In patients with renal impairment, reduced dosage may be necessary. Prospective studies of *Motrin* safety in patients with chronic renal failure have not been done. *Motrin* can inhibit **platelet aggregation** and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy. Patients should report signs or symptoms of **gastrointestinal ulceration** or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema. To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged **corticosteroid therapy** should have therapy tapered slowly when *Motrin* is added. The antipyretic, anti-inflammatory activity of *Motrin* may mask inflammation and fever.

Drug interactions. *Aspirin:* used concomitantly may decrease *Motrin* blood levels.
Coumarin: bleeding has been reported in patients taking *Motrin* and coumarin.

Pregnancy and nursing mothers: *Motrin* should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

The most frequent type of adverse reaction occurring with *Motrin* is gastrointestinal, of which one or more occurred in 4% to 16% of the patients.

Incidence Greater Than 1% (but less than 3%)—Probable Causal Relationship

Gastrointestinal: Nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence); **Central Nervous System:** Dizziness,* headache, nervousness; **Dermatologic:** Rash* (including maculopapular type), pruritus; **Special Senses:** Tinnitus; **Metabolic/Endocrine:** Decreased appetite; **Cardiovascular:** Edema, fluid retention (generally responds promptly to drug discontinuation; see PRECAUTIONS).

Incidence Less Than 1%—Probable Causal Relationship*

Gastrointestinal: Gastric or duodenal ulcer with bleeding and/or perforation, gastrointestinal hemorrhage, melena, gastritis, hepatitis, jaundice, abnormal liver function tests; **Central Nervous System:** Depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma; **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome, alopecia; **Special Senses:** Hearing loss, amblyopia (blurred and/or diminished vision, scotomata, and/or changes in color vision) (see PRECAUTIONS); **Hematologic:** Neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura, eosinophilia, decreases in hemoglobin and hematocrit; **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure, palpitations; **Allergic:** Syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasm (see CONTRAINDICATIONS); **Renal:** Acute renal failure in patients with preexisting, significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria; **Miscellaneous:** Dry eyes and mouth, gingival ulcer, rhinitis.

Incidence Less Than 1%—Causal Relationship Unknown*

Gastrointestinal: Pancreatitis; **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri; **Dermatologic:** Toxic epidermal necrolysis, photoallergic skin reactions; **Special Senses:** Conjunctivitis, diplopia, optic neuritis; **Hematologic:** Bleeding episodes (e.g., epistaxis, menorrhagia); **Metabolic/Endocrine:** Gynecomastia, hypoglycemic reaction; **Cardiovascular:** Arrhythmia (sinus tachycardia, sinus bradycardia); **Allergic:** Serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis; **Renal:** Renal papillary necrosis.

*Reactions occurring in 3% to 9% of patients treated with *Motrin*. (Those reactions occurring in less than 3% of the patients are unmarked.)

**Reactions are classified under *"Probable Causal Relationship" (PCR)* if there has been one positive rechallenge or if three or more cases occur which might be causally related. Reactions are classified under *"Causal Relationship Unknown"* if seven or more events have been reported but the criteria for PCR have not been met.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Do not exceed 2400 mg per day. If gastrointestinal complaints occur, administer with meals or milk.

Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Caution: Federal law prohibits dispensing without prescription.

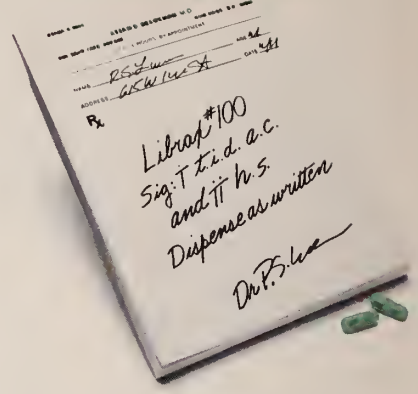
Upjohn THE UPJOHN COMPANY
Kalamazoo, Michigan 49001 USA

MED B-5-S

J-9042-4

July 1981

Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

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of Irritable Bowel Syndrome* and Peptic Ulcer*

Librax...the only G.I. medication that provides the action of Librium® (chlordiazepoxide HCl) to relieve the accompanying anxiety found in some patients, plus the action of Quarzan® (clidinium bromide) to reduce colonic spasm and gastric hypersecretion.

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Adjunctive

Librax®

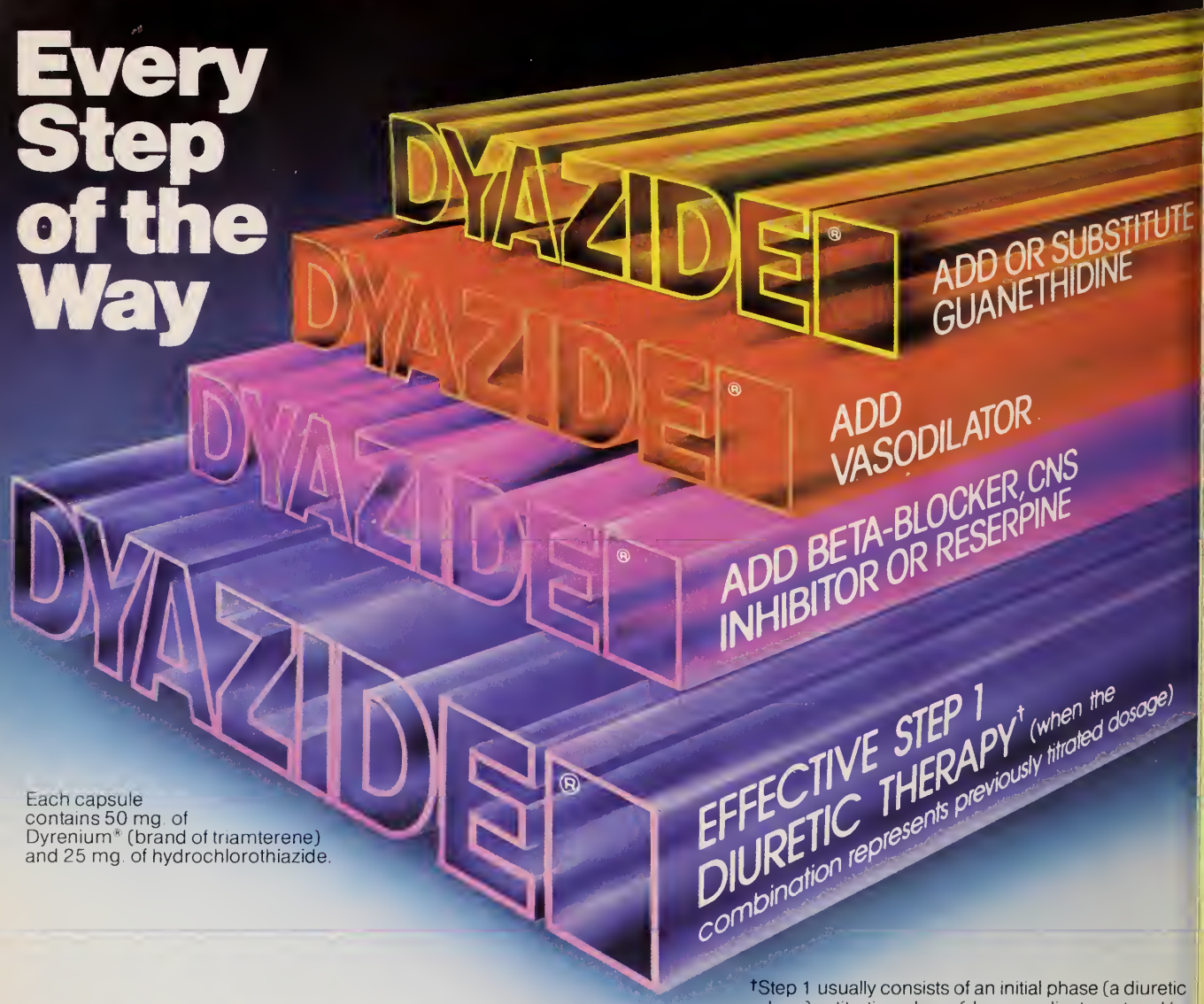
Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/ Antispasmodic

*Librax has been evaluated as possibly effective for these indications. Please see summary of prescribing information on facing page.

In Hypertension*...When You Need to Conserve K

Every Step of the Way



Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent), a maintenance phase (a diuretic alone or in combinati with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. The following is a brief summary.

* **WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently, both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective mea should be instituted cautiously and serum potassium determined. Discontinue corrective measures and 'Dy should laboratory values reveal elevated serum potas Chloride deficit may occur as well as dilutional hyponatr Serum PBI levels may decrease without signs of th disturbance. Calcium excretion is decreased by thia 'Dyazide' should be withdrawn before conducting tes parathyroid function.

Diuretics reduce renal clearance of lithium and increas risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizzi headache, dry mouth, anaphylaxis, rash, urticaria, p sensitivity, purpura, other dermatological conditions; na and vomiting, diarrhea, constipation, other gastrointe disturbances. Necrotizing vasculitis, paresthesias, ic pancreatitis, xanthopsia and, rarely, allergic pneum have occurred with thiazides alone. Triamterene has found in renal stones in association with other usual cal components. Rare incidents of acute interstitial nephriti of impotence have been reported with the use of 'Dya although a causal relationship has not been establishec

Supplied: Bottles of 1000 capsules; Single Unit Pacl (unit-dose) of 100 (intended for institutional use on Patient-Pak™ unit-of-use bottles of 100.

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Medical Yellow Pages

RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

Energetic Family Practitioner needed to join busy group practice consisting of four physicians. Central Wisconsin town of 15,000 with drawing area of 25,000. Excellent salary first year with many fringe benefits. Full partnership next year. Send CV to Merrill Medical Associates, SC, 716 E 2nd St, Merrill, Wis 54452. 9-11/81

Experienced Emergency Physician sought for four-man group, Southeastern Wisconsin. Annual visits 24,000. Modern facility with full specialty back-up. Equal sharing shifts. Fee for service. 90 K per annum. Emergency experience desirable. ACLS. Send CV or call R J Krill, MD, 3801 Spring St, Racine, Wis 53405; ph 414/636-4011. 9-10/81

Family or General Practitioner. Two-doctor clinic recruiting family or general practitioner who desires long-term residence in vacation country of northeast Wisconsin. Board certification and previous experience preferred but not required. Twenty to thirty OB cases per year as part of general family practice. 100-bed hospital 12 miles. Guaranteed salary and/or net income split possible. More than 30 lakes within 10 miles offer fishing, boating. Excellent opportunity for physician who desires outdoor activities. Send resume to Mr Glen Safford, Chippewa Health Center, Lac du Flambeau, Wis 53538; ph 715/588-3371. EOE, M/F. 9/81

Opportunities for General and Vascular Surgeon and Orthopedic Surgeon. SE Wisconsin location. Close to Milwaukee, Madison, and Chicago. Our facility is immediately adjacent to 126-bed hospital. Good salary structure with incentive program for first year. If you are interested in further information, please contact Administrator, Burlington Medical Center, 190 Gardner Ave, Burlington, Wis 53105. p9-10/81

Obstetrician-Gynecologist, Board certified or eligible, to join 13-physician multispecialty group in metropolitan Milwaukee. Community of 31,000 offers excellent cultural, educational, and recreational facilities. Guaranteed first-year salary plus incentive. Ownership and comprehensive fringe benefit program available after one year. Send CV or inquiries to: PO Box 97, Butler, Wis 53007. 7tfn/81

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We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

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Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095

p1-12/81

Internist, with or without a subspecialty, wanted to join Milwaukee Internal Medicine Group. First-year salary negotiable. Opportunity to join corporation. Excellent fringe benefits and retirement plan. Contact: Administrator, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 7-9/81

General and vascular surgeon, FACS, Board certified, highly qualified, with several years of practice, would like to join an individual or group with an established practice in metropolitan Milwaukee area. Contact Dept 493 in care of the Journal. 7tfn/81

Fifty-physician multispecialty clinic in West Central Wisconsin wants family practitioner for nearby satellite office, allergist, cardiologist (non-invasive), neonatologist, orthopedic surgeon, otolaryngologist, psychiatrist, pulmonary disease internist. Excellent cultural, education, and recreational facilities. 90 miles from Minneapolis. Please contact James R Jepsen, Administrator, Midelfort Clinic, Ltd, 733 West Clairemont Ave, Eau Claire, Wis 54702 or call 715/839-5266. 7-9/81

Orthopaedic surgeon. Board eligible or certified to join established orthopaedist in central Wisconsin community of 18,000 with 36,000 service area. Progressive practice. Modern, well-equipped, 126-bed hospital. Excellent schools. Ideal family community. Salary open. Contact Dr McDonough, Riverview Hospital Medical Office Building, 400 Dewey St, Wisconsin Rapids, Wis 54494. Phone 715/421-5257 office; 715/325-2421 home. 7-9/81

Family Practice. General Clinic—Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Pediatrician to join 3-BC pediatricians in city of 50,000. Good hospital with specialties well represented. Good schools, recreation with many lakes, university. Address replies with CV to: John B Hughes, MD, Oshkosh Children's Clinic, 645 Doctors Court, Oshkosh, WI 54901. 8-10/81

Psychiatrist for comprehensive community mental health system located in South Central Wisconsin thirty miles from Madison and ninety minutes from Chicago. The Rock County system operates its own nursing home, specialized inpatient units for acutely and chronically mentally ill, alcohol and substance abuse, psychogeriatric, and retarded, as well as a day hospital and two mental health clinics. A Board Certified or Board Eligible psychiatrist eligible for Wisconsin license interested in medically-oriented multidisciplinary care. Salary to mid-fifties plus full fringe benefits including one month vacation and paid malpractice. Contact M J Chapman, MD, Medical Director, Rock County Health Care Center, PO Box 351, Janesville, WI 53545; ph 608/755-2527. An EOE. 9/81

Physicians Exchange

continued

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties. *Anesthesiology, Family Practice, Hematology/Oncology, Neurology* and *Otolaryngology.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 7tfn/81

Racine Medical Clinic, multispecialty group of 22 physicians has a practice association for internist. The clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406. Phone 414/886-5000. 5tfn/81

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Board certified or eligible family practitioners, OB-GYN and surgeon wanted to join expanding multispecialty group located in South Central Wisconsin near major metropolitan area. Excellent salary structure and benefits first year with options thereafter. Interested physicians inquire immediately. All requests to be answered immediately and in confidence. Write Dept 488 in care of the Journal. 5tfn/81

Pediatrician wanted to practice in conjunction with a 4-member Pediatric Dept of a 23-physician multispecialty group, located in upper midwest. Must be Board certified or eligible. Position open immediately. Please contact Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. 414/632-7521. 2tfn/81

General Internists. Board Certified or Eligible, to join 40-physician multispecialty medical group located on Milwaukee's east side overlooking Lake Michigan. Adjacent to 300-bed hospital. Salary plus bonus and comprehensive fringe benefit package. Contact Eugene Daun, Administrator, Northpoint Medical Group, Ltd, 2388 North Lake Drive, Milwaukee, Wis 53211. 9-10/81

DIRECTOR, GRADUATE EDUCATION. The Department of Family Practice, The Medical College of Wisconsin, seeks a Board Certified Family Practice physician who will provide direction to six Family Practice Residency Programs (114 residents) in areas of curriculum, teaching development, evaluation and other special projects. Individual must give evidence of achievement and leadership; demonstrate effectiveness as a teacher; is knowledgable about residency program management; and maintains current clinical skills. This is a newly created position. Please direct inquiries to Thomas F Garland, MD, Acting Chairman, Dept of Family Practice, The Medical College of Wisconsin, Seton Tower, 2315 North Lake Drive, Milwaukee, Wis 53211. The Medical College of Wisconsin is an Equal Opportunity Employer. 8-9/81

Physician's Assistant seeks relocation. Have national-Wisconsin state certification. Experience in rural primary care and general surgery. Prefer small community or rural family practice in Southeastern Wisconsin. Resume and references upon request. Contact Dept 494 in care of the Journal. 9tfn/81

Fond du Lac—26 physician incorporated multispecialty group on the south shore of Lake Winnebago needs a fourth pediatrician. Guaranteed salary with full shareholder status available after one year. Send CV to Kirk A Veit, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 9tfn/81

Family Physician wanted to join an established two physician group practice in Northeast Iowa community of Cresco. A generous first-year guaranteed compensation plan is offered with option to buy into practice after one year. Practice is located adjacent to a 42-bed, acute care community hospital. Cresco is a city of 4,000 located 60 miles from Rochester, Minn, and 70 miles from LaCrosse, Wis. Cresco is a family oriented community with excellent schools and recreation. Northeast Iowa is noted for its excellent fishing and canoeing on the Upper Iowa River. An excellent par 36 golf course is located in Cresco. Contact Peter Kepros, MD or Tom Kafka, MD at 319/547-2022, 321 8th Avenue West, Cresco, Iowa 52136. p9/81

Internist with training in pulmonary disease needed to join a 22-physician multispecialty group in Appleton, Wis. Excellent hospitals, guarantee plus incentive compensation. Complete benefit package. Medium size community. Contact Art Schuetze, Administrator, Medical Arts Clinic, SC, 401 N Oneida St, Appleton, Wis 54911. Phone 414/739-0171. 9-11/81

Orthopedic Surgeon to join an established two-man department in a multispecialty group located adjacent to an expanding medical center in Western Wisconsin. The community offers a wide variety of year-round cultural and recreational opportunities for the entire family. Our corporate organization offers a generous first-year guaranteed salary and production-incentive income thereafter. The fringe benefit package is all inclusive and most attractive. Contact Director of Professional Affairs, Skemp-Grandview-LaCrosse Clinic, Ltd, 815 S 10th St, LaCrosse, Wis 54601. 9-11/81

Neurologist to join a three member neurology/neurosurgery group in Waukesha County. Negotiable salary with potential for full partnership after one year. Contact: James C Hanson, MD, Neurologic Associates of Waukesha Ltd, 1111 Delafield St, Waukesha, Wis 53186. p9-11/81

Emergency Physicians. Full-time openings for ER physicians with group serving hospitals in Manitowoc, Sheboygan, Wisconsin Rapids, Shawano, Oconto Falls, and other cities. Excellent starting salaries, flexible schedules. Must be willing to relocate to area. Send CV to: Central States Emergency Physicians, PC, 1846 Hoffman St, Suite 101, Madison, Wis 53704 or ph 1/800-362-7366. 7-12/81

Surgeon with thoracic general vascular training, Pediatrician, and Ophthalmologist to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

Family or General Practitioner wanted at small town clinic in NW Wisconsin within one hour of Duluth. Rural area offers fishing, boating, hunting, skiing. Fully equipped clinic and support staff provided. Salary plus benefits and/or net income split. Send resume to WH Erskine, NWMC, Box 86, Minong, WI 54859; or call 715/466-2201. 8tfn/81

Practice opportunities for: *Opthalmologist, Neurologist, Psychiatrist, Family Practice (satellite locations). Internal Medicine w/subspecialty (except Gastroenterology).* Board eligible or board certified, to join 50-man multispecialty practice in southern Wisconsin, 45 minutes to Madison, two hours to Milwaukee. Perfect location for good family living. Contact: R E Hassler, MD, The Monroe Clinic, Monroe, Wis 53566 or ph 608/328-7000. 7-9/81

Two Family Practice Physicians sought to assume a fully operational practice in a community 30 miles north of Madison, Wisconsin. New clinic facility. Income guaranteed. Physician back-up available. Board certified or eligible preferred. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 5tfn/81

Milwaukee Internal Medicine Group wishes to share office space with any medical specialty in its well-equipped satellite office. Contact: Administrator, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 7-9/81

Emergency Medicine Opportunities. Directorship and clinical positions available in the greater Milwaukee area. Excellent income, paid malpractice insurance, and flexible scheduling provided. For details, send credentials in confidence to Michael Dixon, 970 Executive Parkway, St Louis, MO 63141; or call toll-free 1/800-325-3982. 5-10/81

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

General Surgeon available. Thirteen years of solid experience, including rural and metropolitan practice. Seeking relocation to smaller community to join a group or hospital staff. Contact: Robert T Bock Agency, 2733 Newcastle, Waukesha, Wis 53186. Tel: 414/542-4499. (Licensed Employment Agency) p9/81

CompHealth—Locum Tenens. Physicians covering physicians, nationwide, all specialties. We provide cost-effective quality care. Call us day or night. T C Kolff, MD, President, CompHealth, 175 W 200 S, Salt Lake City, Utah 84101; ph 801/532-1200. p7-10/81

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Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
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Phone: (608) 222-2927 *Licensed Employment Agency*

Internist wanted to join a 14-physician multispecialty group in one of northern Wisconsin's finest recreation areas. Modern 109-bed hospital. Excellent professional and personal opportunity. Contact Dr J Wiesner, Lakeland Medical Associates Ltd, Box 549, Woodruff, Wis 54568 or call 715/356-3292. 5tfn/81

Internist wanted, with or without subspecialty, to join long established private practice in Southeastern Wisconsin community of 75,000. Superb hospital facilities, totaling 600 beds. Excellent schools, University, and College facilities. Easy access to Milwaukee and Chicago. Position available now. Call collect 414/654-4562. 8-11/81

Family Practitioner or Internist to join 3-man group in Northern Wisconsin locale offering year-round outdoor activities. Clinic located close to 70-bed general hospital. Partnership first year. Attractive fringe benefits. Contact N L Bugarin, MD, Family Clinic, SC, 221 E Washington Ave, Tomahawk, Wis 54487; ph 715/453-2147. 7tfn/81

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Family Practice, Internal Medicine and Pediatric positions available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303; ph 414/494-5611. 9-12/81

Attractive Emergency Room Opportunity. Lake Geneva area. Day shifts. Guaranteed minimum. Contact William Lange at Lakeland Hospital. Phone 414/723-2960. 9tfn/81

Medical Facilities

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

For Sale: Hamilton examining room table and matching cabinet. Like new. Phone: 414/453-6432, Milwaukee. 8tfn/81

Milwaukee Suburb Family Practice available near Elmbrook Hospital. Low time commitment, yet nets over 50k per year. Donald Wood, MD, 17400 North Ave, Brookfield, Wis 53122; ph 414/786-5400. 8-11/81

Hartland, Wisconsin new office space in refurbished and enlarged medical building. Separate foyer entrance, 800-1100 sq feet. The only medical facility in the immediate area. Phone 414/367-2128. 9/81

EENT used equipment for sale. Telephone 608/233-6571. 9/81*

Equipment for sale. Family practice office equipment for sale. Hamilton examining tables, ECG instruments, sterilizer, copier, consultation, business office, and waiting room furniture, and etc. Milwaukee area. 1-414/762-8160 or 1-414/769-9697. 9/81

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1981 through Aug 31, 1982.

WISCONSIN

SEPTEMBER 30-OCTOBER 2, 1981: *Third Great Lakes Conference on High Blood Pressure Control,* at Milwaukee Marriott Inn, Brookfield. Conference focus will be on the high risk and hard to reach individuals. Topics to be covered: medications management, strategies for the older adult population, patient compliance, pediatric management and operation of comprehensive community high blood pressure control programs. Registration is open to anyone interested in high blood pressure control. Cost: $40 prior to September 18 and $50 after September 18. One CME Category 1 credit towards Physician's Recognition Award of AMA and the American Heart Association will be offered for each hour of participation for a maximum of 10. CEUs also will be available. Great Lakes region includes the states of Wisconsin, Minnesota, Illinois, Indiana, Ohio, and Michigan. Conference is sponsored by Wisconsin Department of Health and Social Services and American Heart Association of Wisconsin. Info: Audrey Koehn, Wisconsin High Blood Pressure Control Program, PO Box 309, Madison, WI 53701.

OCTOBER 2, 1981: *Fall Cardiology Conference,* sponsored by Madison General Hospital ECG Committee. Five hours AMA Category 1 credit; five hours AAFP prescribed credit. Info: Howard B Christensen, CME, 202 S Park St, Madison, Wis 53715; ph 608/267-6386.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
1992—Apr 23-25	

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

OCTOBER 9-10, 1981: *Wisconsin ACEP/EDNA Fall Symposium,* at Pfister Hotel in downtown Milwaukee. National faculty. Further info: Gary L Gerschke, MD, 2025 East Newport Ave, Milwaukee, Wis 53211, or phone 414/961-3508. Credit: 12 hours CME, $60 Wisconsin ACEP members, $125 for nonmembers.—Wisconsin Chapter/American College of Emergency Physicians.

OCTOBER 9-10, 1981: Wisconsin Chapter, American College of Emergency Medicine, Pfister Hotel, Milwaukee.

OCTOBER 9, 1981: *Ophthalmology for the Primary Care Physician,* Madison. Sponsored by University of Wisconsin, School of Medicine, Dept of Ophthalmology; and University of Wisconsin, Extension, Dept of Continuing Medical Education. AMA Category 1; AOA and Family Practice credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706; ph 608/263-2856.

OCTOBER 14-17, 1981: *Wellness and Cardiovascular Health Symposium,* in celebration of the 10th anniversary of the LaCrosse Exercise Program. Involving: Adult Fitness, Patient Education, School Fitness, Exercise Testing, Community Fitness, Cardiac Rehabilitation, Exercise Physiology, Industrial Fitness, Sports Medicine, and Wellness. Inquiries: LaCrosse Exercise Program-Workshop Unit, Mitchell Hall, UW-L, LaCrosse, Wis 54601 (ph 608/785-8686).

OCTOBER 17-18, 1981: *Therapeutics III—1981,* Madison. Sponsored by University of Wisconsin, School of Medicine, Dept of Medicine; and University of Wisconsin, Extension, Continuing Medical Education. AMA Category I; University of Wisconsin continuing education units; AOA and Family Practice credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706; ph 608/263-2856.

OCTOBER 22-24, 1981: *Radiology and Breast Cancer,* Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Radiology. AMA Category I, University of Wisconsin continuing education units, ACR pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706; ph 608/263-2856.

OCTOBER 30-31, 1981: *Osteoporosis,* Madison. University of Wisconsin, Extension, Dept of Continuing Education; and University of Wisconsin, School of Medicine, Department of Preventive Medicine. AMA Category 1; AOA and family practice credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706; ph 608/263-2856.

NOVEMBER 9, 1981: *Suicide Assessment and Intervention,* Baraboo. Sponsored by University of Wisconsin-Extension, Department of Allied Health and University of Wisconsin-Extension, Department of Mental Health. Approved 6 credit hours in Category 1 of AMA and University of Wisconsin-Extension CEU. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 10, 1981: *Suicide Assessment and Intervention,* Milwaukee. Sponsored by University of Wisconsin-Extension, Department of Allied Health; and University of Wisconsin-Extension, Department of Mental Health. Approved 6 credit hours in Category I of AMA and University of Wisconsin-Extension CEU. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 12-14, 1981: *Current Concepts in Respiratory Intensive Care,* Wisconsin Center, Madison. Sponsored by University of Wisconsin-Extension, Continuing Medical Education; and University of Wisconsin Department of Nursing, Pulmonary Section of the School of Medicine, and Respiratory Therapy Department, and Center for Trauma and Life Support. Approved 18 credit hours Category I of AMA; University of Wisconsin Continuing Medical Education hours; AOA, Family Practice, and College of Emergency Physicians credit applied for. Fee: $200 Physician; $130 Nurses, Residents, Respiratory Therapists, and Allied Health Professionals. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 13, 1981: Wisconsin Orthopaedic Society, Olympia Resort, Oconomowoc.

NOVEMBER 17, 1981: *Suicide Assessment and Intervention,* Madison. Sponsored by University of Wisconsin-Extension, Department of Allied Health; and University of Wisconsin-Extension, Department of Mental Health. Approved 6 credit hours in Category I of AMA and University of Wisconsin-Extension CEU. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 20-21, 1981: *Boning Up on Tumors of Bone,* Wisconsin Center, Madison. Sponsored by University of Wisconsin School of Medicine, Division of Orthopedic Surgery and Department of Pathology; and University of Wisconsin-Extension, Department of Continuing Medical Education. Approved 11 credit hours of Category I AMA-PRA, American Osteopathic Association Category 2-D, AAFP elective credit, University of Wisconsin Continuing Education credit. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JCAH education seminars

Medical staff issues and the practicing physician

Forum for physicians to discuss medicolegal concerns, medical staff organization, delineation of privileges and clinical reappointment, quality assurance requirements, and standards that direct the functions of the medical staff. Clinical faculty for these exciting and important seminars include several prominent practicing physicians, a JCAH physician surveyor, and an attorney.

Seminars will be offered in the following locations and on weekend dates that lend themselves to physicians' busy schedules:

August 7-9: The Greenbrier, White Sulphur Springs, West Virginia

October 23-25: Innisbrook, Tarpon Springs, Florida

November 6-9: Las Vegas, Nevada

November 20-22: Lakeway Inn, Austin, Texas

For further info: Julie Efaw, JCAH Headquarters, 875 N Michigan Ave, Chicago, IL 60611. Phone: 312/642-6061, ext 353.

As an organization accredited for continuing education, JCAH has determined that this CME activity meets the criteria for 11 credit hours in Category I of the Physician's Recognition Award of the AMA.

DECEMBER 11-12, 1981: *Coronary Artery Disease—the View in 1981,* Wisconsin Center, Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Medicine, Division of Cardiology and Department of Surgery, Division of Thoracic and Cardiovascular Surgery, and University of Wisconsin-Extension, Department of Continuing Medical Education. Approved 12 credit hours Category I of AMA-PRA; AOA Category 2-D, University of Wisconsin-Extension, Continuing Education Hours; AAFP credit applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

FEBRUARY 25-28, 1982: Wisconsin Psychiatric Association, Lake Lawn Lodge, Lake Delavan.

MIDWEST

DECEMBER 9-11, 1981 (Illinois): *Neurology for the Non-Neurologist,* sponsored by Rush Presbyterian-St Luke's Medical Center at Chicago Marriott Hotel, Chicago. AMA Category I credit: 20 hours. Contact: Linda Carter, Office of Continuing Education, Rush Presbyterian-St Luke's Medical Center, 600 South Paulina St, Chicago, Ill 60612; ph 312/942-7095.
9-10/81

OTHERS

OCTOBER 17-21, 1981 (Louisiana): Annual Meeting, American Society of Anesthesiologists, New Orleans. Info: ASA, 515 Busse Highway, Park Ridge, Illinois 60068 (ph 312/825-5586).

OCTOBER 23-25, 1981 (Florida): *Medical staff issues and the practicing physician* seminar by JCAH, at Innisbrook, Tarpon Springs, FL. Registrar: Charlotte Wells, Florida Hospital Association, PO Box 6905, Orlando, FL 32853 (phone: 305/841-6230).

OCTOBER 26-29, 1981 (Georgia): 66th Annual Scientific Assembly of Interstate Postgraduate Medical Association at the Atlanta Marriott Hotel, Atlanta. Info: Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701.
g9/81

MINNESOTA MEDICAL ASSOCIATION
Resource Group on Rheumatic Diseases
presents

RHEUMATOLOGY SEMINAR IV
and
A WEEK ON CAPTIVA ISLAND, FLORIDA
February 27—March 6, 1982

AUDIENCE: Primary care physicians, orthopedists

CONTENT: Common rheumatologic problems: early diagnosis and the natural course of rheumatic diseases in children and adults, drug management, and surgical considerations with a current update of research in rheumatic diseases.

HOURS: 20 hours, Category 1/Prescribed

TOUR PACKAGE: Includes round-trip flight, accommodations for seven nights and car rentals. Depart Twin Cities Airport, February 27; return March 6.

FEES: Educational program-$250; Tour package-from $589/person for double occupancy.

CONTACT: Minnesota Medical Association, Suite 400, Health Associations Center, 2221 University Ave, SE, Minneapolis, Minn 55414; ph 612/378-1875.
9-10/81

OTHERS (cont)

OCTOBER 31-NOVEMBER 5, 1981 (New Orleans, La): American Academy of Pediatrics 1981 Annual Meeting, New Orleans, La. Info: American Academy of Pediatrics, PO Box 1034, 1801 Hinman Ave, Evanston, Ill 60204.

NOVEMBER 6-9, 1981 (Nevada): *Medical staff issues and the practicing physician* seminar by JCAH, at Las Vegas, Nev. Registrar: Julie Efaw, Joint Commission on Accreditation of Hospitals, 875 N Michigan Ave, Chicago, IL 60611 (phone: 312/642-6061).

NOVEMBER 10-14, 1981 (Texas): *Cancer 1981/2001—An International Colloquium,* Shamrock Hilton Hotel, Houston, Tex. Sponsored by the University of Texas MD Anderson Hospital and Tumor Institute at Houston. Info: University of Texas System Cancer Center, MD Anderson Hospital and Tumor Institute Texas Medical Center, 6723 Bertner Ave, Houston, Tex 77030; ph 713/792-3030. g9/81

DECEMBER 8-10, 1981 (Florida): *American Cancer Society National Conference-Gastrointestinal Cancer-1981,* Fontainebleau Hilton Hotel, Miami Beach, Fl. Approved 13 credit hours Category 1 of AMA-PRA and AAFP. Info: Nicholas G Bottiglieri, MD, American Cancer Society, National Conference-Gastrointestinal Cancer-1981, 777 Third Ave, New York, NY 10017.

FEBRUARY 8-12, 1982 (Idaho): *Scientific/Ski Meeting:* The Northwestern Medical Association convenes for its 35th Annual Meeting at Sun Valley, Idaho. Diabetes and related vascular, neurologic, eye, and ENT problems, ski-injury prevention, and high-altitude physiology will be discussed by experts. Approved for 10 CME Category I credits. Registration 3 to 5 pm, February 8, Challenger Inn, Sun Valley. Nonmembers registration $100. Info: Norman Christensen, MD, Secretary, 2456 Buhne St, Eureka, Calif 95501. 9-10/81

FEBRUARY 27-MARCH 6, 1982 (Capitiva Island, Florida): 20 hours, Category 1/prescribed. For primary care physicians. Contact Minnesota Medical Assn, Suite 400, Health Association Ctr, 2221 University Ave, SE, Minneapolis, MN 55414, ph 612/378-1875. 8/81

MAY 16-20, 1982 (Brazil): *The Fifth International Symposium on the Prevention and Detection of Cancer, San Paulo, Brazil.* Sponsored by Fundacao "Centro de Pesquisda de Oncologia" and The International Society for Preventive Oncology; Info: Medical Congress Coordinators Department, 1212 Avenue of the Americas, New York, NY 10036; ph 212/840-0110. g8-12/81; 1-4/82

HEALTH CARE COST CONTAINMENT SEMINAR

October 12-14, 1982—Palm Springs, California—Spa Hotel

First such seminar to be held by the International Foundation of Employee Benefit Plans, John L Watts, president.

Purpose is to give representatives of employee hospital-medical benefit plans information and insight needed to plan and implement effective cost containment programs.

An overview of the US health delivery system will kick off the three-day program, followed by presentations on health care costs and the role of health planning; the position of the Reagan Administration; cost containment through plan design; cost containment through administration; cost savings and benefits of alcoholism, drug, and other special programs, and the future of benefit plans.

Registration fee for Foundation members and nonmembers alike will be $360 each.

More information may be obtained by writing or telephoning the International Foundation of Employee Benefit Plans, PO Box 69, Brookfield, Wisconsin 53005. Telephone 414/786-6700.

SNOWMASS/VAIL "MEP" SKI SEMINAR

On Management Enrichment for the Health Professional

Ski Snowmass, Colorado the week of December 19, 1981 or the week of March 20, 1982; or ski Vail, Colorado the week of February 20, 1982. Seminars conducted by noted doctors and management specialists to enrich your life. Seminars comply with IRS rules to make trip expenses deductible for doctor and spouse. For brochure and lodging information contact: MEP, An Education Corporation, 906 Cooper Ave, Glenwood Springs, Colorado 81601; or call 800/525-3402. 6-9/81

AMA

DECEMBER 6-9, 1981: Interim AMA House of Delegates, Las Vegas, Nev.

FEBRUARY 25-28, 1982: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl. ■

AMA SYMPOSIUM

Diet and Exercise:Synergism in Health Maintenance

NOVEMBER 3-4, 1981
Lake Buena Vista, Florida

(Walt Disney World Complex)

Symposium will focus on the role of nutrition *and* exercise in the promotion of health and the treatment of major health problems. Emphasis will be on the physiologic effects of moderate habitual activity coupled with sound nutrition practices; *ie,* the role of nutrition and exercise in health maintenance and in the treatment of some of our chronic degenerative disease states.

Sponsored by the Department of Foods and Nutrition, American Medical Association, in conjunction with the AMA's Council on Scientific Affairs and Council on Continuing Physician Education, and the Florida Medical Association.

For further information contact: Department of Foods and Nutrition, AMA, 535 N Dearborn St, Chicago, IL 60610.

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1981-1982

Wisconsin Society of Anesthesiologists, Sept 18-20, 1981, Lake Lawn, Lake Delavan

Wisconsin Dermatological Society, Oct 24, 1981, Froedtert Memorial Lutheran Hospital, Milwaukee; and Feb 27, 1982, University of Wisconsin Center for Health Sciences, Madison

Wisconsin Neurosurgical Society, September 18-19, 1981, Madison

Wisconsin Society of Obstetrics & Gynecology, June 11-13, 1981, Telemark Lodge, Cable

Wisconsin Section, American College of Obstetricians & Gynecologists (District VI), Sept 9-12, 1981, Minneapolis, Minn

Wisconsin Society of Otolaryngology, Aug 29-30, 1981, Maxwelton Braes Resort, Baileys Harbor

Wisconsin Society of Pathologists, October 1981

Wisconsin Chapter, American Academy of Pediatrics, Sept 11-12, 1981, University of Wisconsin Clinical Science Center, Madison

Wisconsin Radiological Society, Oct 10, 1981, Concourse Hotel, Madison

***

SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, May 13-15, 1982, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

MIDWEST Regional CME meetings American College of Physicians

SEPTEMBER 19-20, 1981 (Illinois): Drake Hotel, Chicago. Info: Rolf M Gunnar, MD, FACP, Loyola University Medical Center, 2160 S First Ave, Maywood, IL 60153.

OCTOBER 8-11, 1981 (Michigan): Boyne Highlands, Harbor Springs. Info: Boy Frame, MD, FACP, 543 Lakepointe, Grosse Pointe Park, MI 48230.

OCTOBER 15-17, 1981 (Missouri): Almedea Plaza Hotel, Kansas City. Info: Davis M Kipnis MD, FACP, Dept of Medicine, Washington University School of Medicine, 660 S Euclid, St Louis, MO 63110.

OCTOBER 1981 (Minnesota): Rochester. Info: John A Spittell Jr, MD, FACP, Mayo Clinic, 200 First St SW, Rochester, MN 55901.

NOVEMBER 20, 1981 (Indiana): Hilton Hotel, Indianapolis. Info: Walter J Daly, MD, FACP, Indiana University Medical Center, Emerson Hall, Room 317, 1100 W Michigan St, Indianapolis, IN 46223.

Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Scorpions of Medical Importance. By Hugh L Keegan. 1981. University Press of Mississippi, 3825 Ridgewood Rd, Jackson, MS 39211. Pp 140. Price: $22.50.

Mental Health in America: The Years of Crisis. Edited by Richard C Allen. 1979. Marquis Academic Media, 200 East Ohio St, Chicago, IL 60611. Pp 380. Price: $12.50.

How To Live With Your Children. By Don H Fontenelle, PhD. 1981. Almar Press, 4105 Marietta Drive, Binghamton, New York 13903. Pp 280. Price: $9.95.

A New Look At Senility. By Albert A Fisk, MD. 1981. Charles C Thomas, Publisher, 301-327 East Lawrence Ave, Springfield, IL 62717. Pp 103. Price: $11.75.

Contemporary Theories of Schizophrenia. By Sue A Shapiro, PhD. 1981. McGraw-Hill Book Company, 1221 Avenue of the Americas, New York, NY 10020. Pp 289. Price: $18.95. ■

Advertisers

Acme Laboratories 39
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Neosporin® Ointment
Dista Products Co (Div of Eli Lilly & Co) ..... FC
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Spectrum Emergency Care, Inc 45
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United States Army Medical Department 46
Upjohn Co 55
Motrin®
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Wygesic® ■

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

PHYSICIANS PRIMARY SOURCE OF IMMUNIZATION. Physicians were the source of more than 67% of immunizations of children for preventable diseases, a recent survey of the State Division of Health shows. The random sample of children born in 1978 also showed that the number of immunizations completed were somewhat higher when given by physicians. Almost 19% of the children surveyed received their immunizations from public health agencies, and more than 13% received immunizations from both physicians and public health agencies. Since nearly all of the children surveyed had received at least one immunization, the Division of Health believes the key to increasing the percentage who complete all their immunizations is following up on those who fail to return on schedule. The use of tickler files will quickly identify the delinquent so they can be reminded of their missed immunization, the Division says.

AMA DUES INCREASE. A $35 annual dues increase was approved by the AMA's House of Delegates to support a major restructuring of AMA's reorganization and staff. The House also accepted the principle of considering annual increases of $30 and $25 over the next two years, subject to approval each year by the House.

DOD PROPOSES TO END COVERAGE OF RESIDENTIAL TREATMENT CENTER CARE UNDER CHAMPUS. The Department of Defense has proposed to discontinue residential treatment centers (RTCs) as authorized providers under CHAMPUS. If the proposal is finally approved, CHAMPUS benefits would end for admissions to RTCs as of Oct 1, 1981. To provide for an orderly transition, however, individuals who are in an RTC on Oct 1, 1981, could continue to receive CHAMPUS benefits for RTC-level care for up to one year, based on individual case review. As of Oct 1, 1982, all benefits for RTC care would end. CHAMPUS benefits will continue to be available for medically necessary inpatient psychiatric hospital care or outpatient psychotherapy.

MORE ON BLUE CROSS & BLUE SHIELD UNITED AMBULATORY SURGERY PROGRAM. In response to an announcement by Blue Cross & Blue Shield United to initiate an ambulatory surgery program for nine high frequency procedures, several clinics and physicians have requested the firm to consider compensating physicians for additional overhead and incidental expenses incurred when performing certain surgical procedures in their offices. Blue Cross & Blue Shield United has decided the proposal has merit and will implement this program on a demonstration project basis for eleven surgical procedures. The procedures include: Arthroscopy, Biopsy or excision of lymph node, Esophagoscopy/Esophagogastroscopy, Gastroscopy with biopsy or biopsies, Left or right colonoscopy with biopsy, Breast biopsy, Excision of ganglion, Carpal tunnel, Bronchoscopy, Cystoscopy, Vasectomy. Additional payments for office supplies and related expenses up to $40.00 will be made whenever one of these surgical procedures is performed in a physician's office. At the end of one year, the results and effected savings will be reviewed to determine whether to continue the program. Questions and comments regarding the program can be directed to the Professional Relations staff at 414/226-6152 or 1-800/242-9035, ext 6152.

COULD IT HAPPEN HERE? Faced with a budget squeeze, the state of Maine is cutting its commitment to medical education and slicing part of its Medicaid expenses. Claiming to be oversupplied with physicians, Maine has virtually withdrawn its support of medical education. The state will now partially fund 18 medical students a year in out-of-state colleges instead of 40. In 1982 the cost of Medicaid looms as the state's greatest single expense. To offset the burden, the state is instituting a system of Medicaid "copayments." It is hoped that the plan will generate some income for the state, reduce demand and prompt patients seeking primary care in hospitals to seek that same care in the offices of private physicians.

1982 JOURNALISM AWARDS COMPETITION. Each year the American Academy of Family Physicians sponsors a Journalism Awards Competition to recognize the most significant and informative reporting and writing on family practice and healthcare. Awards totaling $7,500 will be given in both print and broadcast categories. Reporters, feature writers, syndicated staff writers, newscasters, or other members who deal with medical news or features are eligible. Entries are due Nov 15, 1981. For further details contact the American Academy of Family Physicians, 1740 West 92nd Street, Kansas City, Missouri 64114. ■

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WISCONSIN MEDICAL JOURNAL

OCTOBER 1981

Special issue: NUTRITION

Three important products from Dista

Nalfon® 200 fenoprofen calcium — 200-mg* Pulvules®

Nalfon® fenoprofen calcium — 300-mg* Pulvules, 600-mg* Tablets

Keflex® cephalexin — 250 and 500-mg Pulvules, 125 and 250-mg Oral Suspensions

*Present as 230.6 mg, 345.9 mg, and 691.8 mg of the calcium salt of fenoprofen dihydrate equivalent to 200 mg, 300 mg, and 600 mg fenoprofen respectively

Additional information available to the profession on request.

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Indianapolis, Indiana 46285

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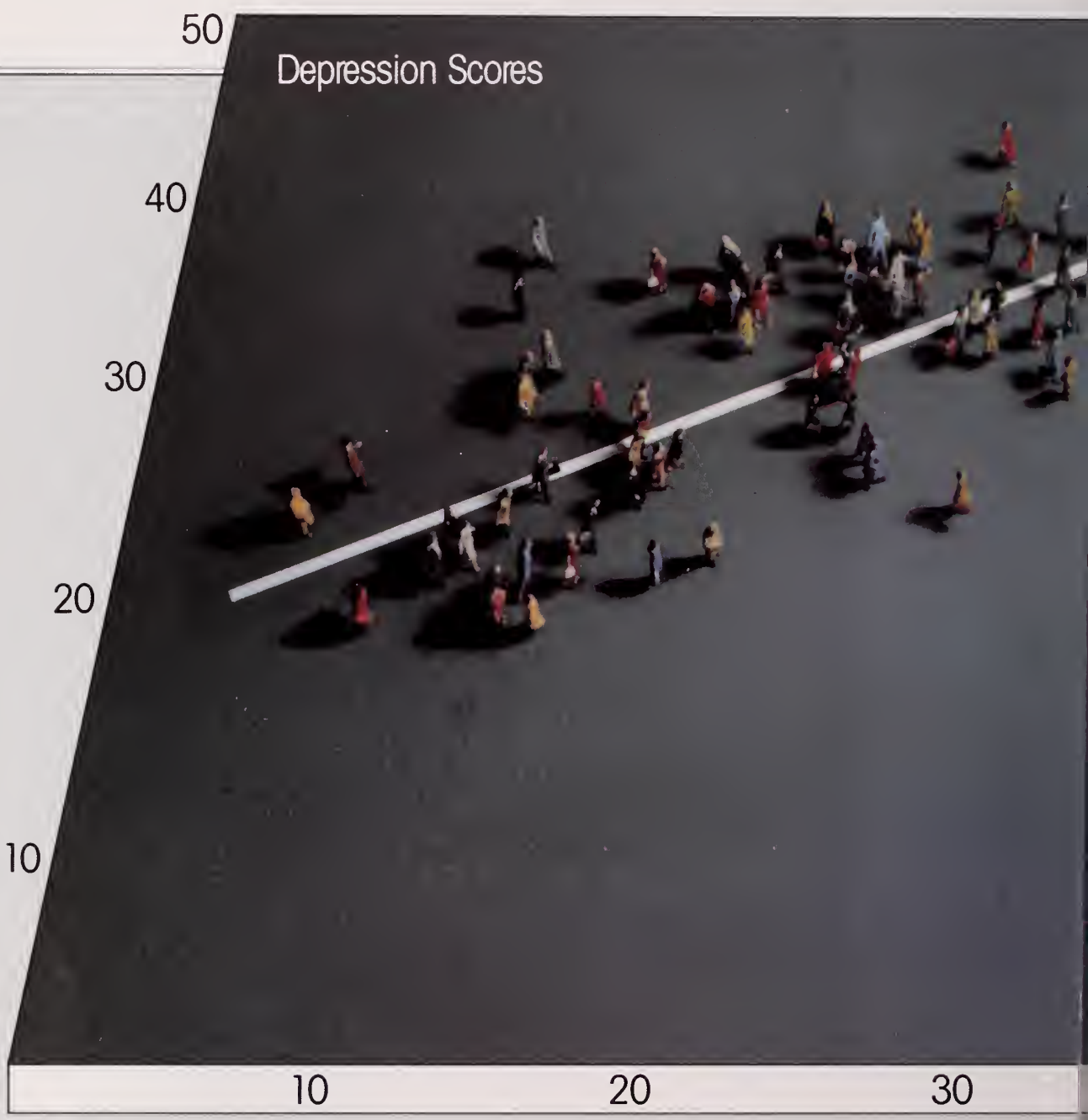

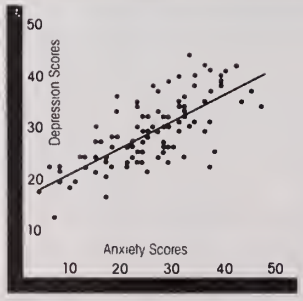

Clear correlation between anxiety and depression[3]

The above graph illustrates a relationship between anxiety and depression, indicating that patients seldom present with anxiety or depression alone; more often they have both in varying degrees. Data based on a sampling of 100 outpatients (64 male; 36 female) seen at a general psychiatric clinic.

[3]Adapted from Clugham, J. The anxiety-depression syndrome. *Psychosomatics 11*:438-441, Sept-Oct 1970.

ROCHE

EPRESSED PATIENTS WHO ARE ALSO ANXIOUS[1,2]

Most depressed patients are also anxious...

Some authors estimate that 70% of all nonpsychotic patients with symptoms of depression have concomitant symptoms of anxiety.[1,2] One author found a distinct correlation between anxiety and depression scores in 100 nonpsychotic outpatients administered the Minnesota Multiphasic Personality Inventory in a general psychiatric clinic.[3] As depression scores increased, so did anxiety scores. No attempt was made to select patients other than to exclude psychotics.

but not psychotic

The logic of treating both components of anxious depression is clear. Antipsychotics, like the phenothiazines, however, carry a well-documented risk of tardive dyskinesia.[4] Because of this, an APA Task Force recently recommended the judicious use of phenothiazines in cases other than chronic psychosis or the use of alternative treatments.

A better way to give relief

Limbitrol combines the specific anxiolytic action of Librium® (chlordiazepoxide HCl/Roche)—a benzodiazepine with a long history of safe use—with the antidepressant action of amitriptyline, a tricyclic of established clinical efficacy. In comparison to phenothiazines, Limbitrol and its components have rarely been associated with tardive dyskinesia or other extrapyramidal side effects. And in terms of rapid response and patient compliance, Limbitrol appears to be superior to amitriptyline alone. Controlled multiclinic studies showed Limbitrol relieved more symptoms more rapidly than did amitriptyline.[5] Despite a higher incidence of drowsiness, the dropout rate due to side effects was lower with Limbitrol. (See adverse reactions section in summary of product information on next page. As with any CNS-acting agent, patients should be cautioned about driving or using dangerous machines while on therapy with Limbitrol.)

References: 1. Rickels K: Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, ed. Jarvik ME. New York, Appleton-Century-Crofts, 1977, p. 316. **2.** Schatzberg AF, Cole JO: Benzodiazepines in depressive disorders. *Arch Gen Psychiatry 35*:1359-1365, 1978. **3.** Claghorn J: The anxiety-depression syndrome. *Psychosomatics 11*:438-441, 1970. **4.** The Task Force on Late Neurological Effects of Antipsychotic Drugs: Tardive dyskinesia, summary of a task force report of the American Psychiatric Association. *Am J Psychiatry 137*:1163-1172, 1980. **5.** Feighner JP *et al*: A placebo-controlled multicenter trial of Limbitrol versus its components (amitriptyline and chlordiazepoxide) in the symptomatic treatment of depressive illness. *Psychopharmacology 61*:217-225, 1979.

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Please see summary of product information on next page.

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***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
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Adverse Reactions: Most frequently reported are those associated with either component alone drowsiness, dry mouth, constipation, blurred vision, dizziness and blotting Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely
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Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia
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Other Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling
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PRESIDENT'S PAGE continued

If a competitive system is to exist in the area of medical care, it must not be at the expense of good medical care. Peer review and the necessary discipline to assure quality will remain the obligation of the profession.

While there are problems and some dangers in the above suggestion, I believe it deserves serious and vigorous investigation given the alternative of rigid and uncompromising rationing of medical care. I believe that the patient deserves to choose the level of care he desires—that it should be profitable for *him* or *her* to cultivate habits of health—that neither the patient nor industry nor government should bear the cost of the wasteful abuse of health and healthcare. ■

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President's Page

ALBERT J MOTZEL JR, MD

The rationing of medical care PART III: another alternative

IS THERE THEN any solution to the dilemma of increasing demand for medical care, particularly care of marginal value, short of stringent regulation; *ie,* rationing?

Perhaps there is one solution—a solution that many believe is no longer acceptable in our society—a solution that contains significant risks for the providers of medical care (physicians, hospitals, etc)—but a solution that when compared to its alternatives may well be worth investigation and trial. Its possibility may also be enhanced in this unusual era of social change and reevaluation.

I would suggest the return of medical care, partially, to the full economic market. Allow those market "principles," that for so long the "regulators" have said don't operate in the medical care field, to once again play a part. To be sure, medical care is too expensive and necessary a commodity for all but a few to assume the entire risk. But a significant change in the medical insurance field could go far to modify patterns of care and redistribute responsibility among providers and consumers.

Since the 1950s, "first" and even "last" dollar coverage of medical costs increased through such mechanisms as "Usual, Customary and Reasonable" (UCR) plans for physician fees and increasingly comprehensive hospital and emergency coverage. Only occasionally was the patient left with any significant personal cost after a medical encounter nor was the patient really able to influence that cost.

Our object, it would seem, should be to make each patient concerned about the cost of his or her own care. As has recently been pointed out in the *New England Journal of Medicine,* the UCR concept, that seemed thirty years ago to be an ideal solution, fails this test completely. Consider the consequences of a return to an indemnity fee schedule utilizing the technology developed over the past thirty years. Using the computer and the sophisticated coding procedures available, the average (or mean, or median) fee for each procedure for the current year would be easily available. This standard could then be used for the negotiation of the indemnity schedule for the following year. With these accurate and current costs available, the purchasers of the policy could negotiate for a schedule ranging from perhaps 70 to 110 percent of the previous year's average fee. The patient would become responsible for the remainder. The consumer would now have an incentive to exercise discretion in choosing his source of care. In addition he would have a rough guide to the average cost of care in the recent past. At least with regard to cost he would now be an informed and interested purchaser.

The physician, too, with the realization that the patient was certainly paying a portion of the medical cost, would likely be even more discerning in ordering and more prone to discuss the pros and cons of more expensive studies with the patient. The closer physician-patient relationship this would engender might influence the willingness and alacrity with which the patient's portion of the physician's fee was paid. As a matter of fact the patient's own investment into his diagnosis and treatment may bring about a new era of compliance in following instructions and taking medications (If he does not intend to invest the effort to follow medical advice, he will not very likely spend the employer-supplied insurance payment if his own funds are also involved).

The implications in the area of hospital care are also of interest. The hospital operating and supplying services in an economical manner will find the indemnity payment covering a higher percentage (perhaps all) of its total charges and therefore have less at risk for delayed or nonpayment. It may also find its occupancy rate high compared to the inefficient and therefore higher-priced institution.

In conclusion, in such a competitive system the medical profession has an even greater obligation to monitor the quality of physician and hospital care.

continued on preceding page

Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Nutrition, the Wisconsin-Harvard connection

THIS IS A UNIQUE issue of the *Wisconsin Medical Journal.* The scientific section is devoted entirely to the subject of nutrition. Most of the papers originated from the Department of Nutrition at Harvard University, yet all of the authors from Harvard had their training in nutrition at the University of Wisconsin. It seems somewhat incongruous that their schooling in nutrition was at the "Ag School," now called the College of Agricultural and Life Sciences. Much of the early work in nutrition and vitamins originated at Wisconsin, beginning almost 70 years ago. This is appropriate since Wisconsin is a great food-producing state. Many of the giants in the field of nutrition and vitamins did their work or had their training on the Wisconsin campus. Fortunately, this work is still continuing.

There are so many aspects of nutrition that affect medicine, yet nutrition has not in the past been adequately emphasized in medical schools. For example, alcoholics are the most likely to suffer from nutritional deficiencies, and there are still many unanswered questions regarding the complex relationships between alcohol and nutrition. The alcoholic consumes toxic amounts of alcohol and frequently simultaneously does not maintain adequate nutritional support. The diet in pregnancy has finally been adequately emphasized. Proper nutrients are equally important in infancy. Overeating and obesity are a major nutritional problem for North Americans. There is confusion as conflicting reports and recommendations have emerged relative to cholesterol, fibers, and sweeteners among others.

Food fads and bizarre diets have gone through phases of popularity. An example was a patient advised to discontinue her regimen of digoxin, a diuretic, and levothyroxine sodium by a "nutritionist" at a health food store and was further advised to take kelp and several vitamin supplements instead. At another natural foods store the patient consults a chart. For blood pressure (high *or* low) the following herbs were recommended: cayenne, parsley, ginger root, goldenseal root, garlic, and Siberian ginseng. This was supposed to promote overall blood circulation and tend to normalize high *or* low blood pressure to the body's normal level.

Some years ago the Zen Macrobiotic diet was popular. This went through seven phases and diet number seven consisted of nothing but brown rice and sips of tea. When a diet like this is adhered to faithfully, it can result in a case such as was reported of a woman who ended up completely bedridden and near death with classical manifestations of scurvy and severe folic acid and protein deficiency. There also has been a great exploitation of "organic foods." Of course, all foods are organic in a scientific sense in that it means they are made up of carbon, hydrogen, and oxygen occasionally along with some other elements such as nitrogen, phosphorus, etc. Sugar, starch, protein, fat, and the vitamins are all organic compounds. However, the organic food faddist uses the term to mean foods that are raised without chemical fertilizers, generally by the use of compost or manures, and without pesticides of any type. Fertilization does not affect the nutritive quality of foods but obviously affects the yield. This is especially important in terms of feeding the world's population. Inorganic nitrates and phosphates are identical whether they are purchased in large quantities as chemical fertilizers or where they are made in the soil by action of the soil bacteria on the organic nitrogen and phosphorous compound. Realistically, there simply is not enough natural manure to cover the vast fields that nourish the world. The controlled use of pesticides is also necessary if we are to continue to produce sufficient food to feed an ever-expanding population. Doctor Stare has asked if we are interested primarily in feeding insects or in feeding ourselves. The so-called organically grown foods are undoubtedly equal in nutritional value to ordinary foods but they are in no way superior and usually are more expensive and can spoil more readily. A news item last fall quoted a well known physician as stating that "meat should be eaten in moderation although we prefer organic meat." Just what would be the source of inorganic meat?

We are grateful to Doctor Stare for his contributions both to the field of nutrition and to this issue of the *Wisconsin Medical Journal.* We also appreciate the contributions of the other transplanted Wisconsinites and of the authors from the University of Wisconsin. Dr Hector F DeLuca, present chairman of the Department of Biochemistry at the University of Wisconsin, graciously prepared a guest editorial. This outlines the history of the Department and briefly acknowledges the invaluable work of the Wisconsin pioneers in nutrition. —VSF

Basic human needs

ACCORDING TO A World Bank report the basic human needs for development are: five years at school; adequate nutrition; primary health care no more than an hour away; family planning services; at least 20 liters a day of pure water per person within 100 yards of home; and a pit latrine.

Those basic needs certainly are modest enough. And what a contrast to our own squalling if every hospital in town doesn't have a CAT scanner and similar sophisticated equipment! —VSF

Drug paraphernalia

TWENTY-THREE STATES have enacted laws creating penalties for possession, use, manufacture and/or delivery of drug paraphernalia. Wisconsin is *not* one of the 23.

Most of these laws are patterned after the Model Drug Paraphernalia Act drafted by the Drug Enforcement Administration of the US Department of Justice. The Model Act defines the term "drug paraphernalia" and lists specific items, sets forth the criminal acts relating to drug paraphernalia and the accompanying penalties, and finally provides for civil forfeiture of seized drug paraphernalia.

Wisconsin, so frequently a leader and innovator in legislation, should join the other states in decapitating the "head-shops." Obviously, anyone purchasing drug paraphernalia does not plan to use it for smoking corn silk out behind the barn.—VSF■

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Focus on Cross-Country Skiing

The Office of Continuing Medical Education of the University of Minnesota Medical School, with the University's School of Physical Education, Recreation, and School Health Education and Continuing Education and Extension, announces the Second University of Minnesota Sports Medicine Conference: ***Focus on Cross-Country Skiing, at Telemark Lodge, Cable, Wisconsin, December 2-4, 1981.***

Conference will feature current scientific investigations and state-of-the-art reviews of endurance and strength physiology, training, diet, and injuries. Exciting new areas of sports medicine are included with discussions of the immune status of highly trained athletes, the particular problems of female athletes such as amenorrhea, and skiing programs for the blind. Problems associated with winter sports in general, such as frostbite, hypothermia, and the design of medical support units for winter competition will also be discussed. A special highlight of the program will be Paavo Komi from Finland. Doctor Komi is a physiologist responsible for recent major advances in Finland's nordic recreational and racing programs. In addition, special interest workshops and on-snow demonstrations by US Olympic Team personnel are planned.

The conference is intended for physicians, members of the American College of Sports Medicine, coaches, trainers, armed services personnel, recreation directors, interested nordic skiing enthusiasts and competitors, and persons involved in related endurance activities.

This year's conference will be held in Telemark's new sports arena/conference center complex, which includes the nation's only indoor cross-country ski track segment.

As an organization accredited for continuing medical education, the University of Minnesota designates this activity as meeting the criteria for 24 credit hours in Category I of the Physician's Recognition Award of the AMA/ACCME.

Registration fee is $235 for physicians and $145 for all other registrants. Checks payable to University of Minnesota, and mailed to: Lori Wheatcroft, Registrar, CME, University of Minnesota, Box 293 Mayo Memorial Bldg, 420 Delaware Street Southeast, Minneapolis, MN 55455.

Commentary

Conference on aging

Phillip M Green, MD, Marshfield, Wisconsin

On May 5, 1981, the Wisconsin Governor's Capitol Conference on Aging was conducted in Madison. Seventy-five percent of the 860 persons attending the May 5 meeting were 55 years or older. Their message was clear: Older adults want and need to remain independent and productive members of our communities. As physicians and members of the healthcare field, we have a definite role in cooperating with them to fulfill that directive.

Resolutions from the conference's nine caucuses were forwarded to the National White House Conference on Aging. Two of these caucuses and the resolutions which resulted were concerned with the medical aspects of aging.

Within the next five years it is estimated that 15% to 20% of the population of Wisconsin will be greater than 62 years of age. All physicians concerned with the care of these individuals should take note of these specific concerns. It is time to reevaluate the ease with which we refer patients to nursing homes and consider developing options in our respective communities which would help maintain these patients in other settings. Such options would not only benefit our patients but would be a logical and perhaps mandatory direction in light of the ever-shrinking government contribution through Medicare.

While there may not be agreement with every resolution resulting from the state conference, these resolutions provide valuable information and suggest direction for the future. Ignoring these recommendations will not make them disappear. Rather, it is our responsibility to acknowledge, assess and adjust our practices to meet the needs and considerations of this growing segment of our population.

The specific caucus on physical health stated that there is a need to achieve an equitable balance between the acute and chronic health care systems and to give greater recognition to the comprehensive longterm health needs of the elderly. These recommendations included:

1. Older Americans should be guaranteed healthcare designed to maintain health and functioning and most importantly encourage self sufficiency.
2. Older persons should continue to get assistance so that an ever-increasing greater proportion of their incomes, which are fixed, will not be required to meet their medical needs.
3. The bias of institutional care instead of community care should be corrected by Medicare and Medicaid services. Healthcare providers should receive educational training in geriatric healthcare as a condition of certification.
4. Medicare and Medicaid shall be redesigned to assure that beneficiaries are not denied access to systems or providers because of arbitrary rate systems.
5. Staffing in rural and minority communities should be encouraged by the Federal Government.
6. Subsidization of housing for the elderly should be designed to facilitate an individual's highest level of independent physical and social functioning.
7. Low-income, elderly persons should not be denied access to dental care.

Most importantly, this caucus recommended that the American people should not be penalized by spiraling uncontained healthcare costs. The caucus recommended an adequate system of cost containment for healthcare providers.

The caucus on mental health felt that there is a need to recognize the worth of older persons in solving their own problems and that there is a need to broaden the accessibility of mental health services for the elderly. Their recommendations were:

1. Healthcare providers including the mental health community should provide educational programs concerning the mental needs of the elderly to respective communities. Those persons who have received training should be utilized more extensively as outreach workers and aides in mental health, alcohol, and drug programs.
2. Nutritional sites, senior citizen centers, and other congregate settings should be utilized more extensively for individual assessments, referrals, and group mental services.

Doctor Green is from the Department of Neurosciences, Marshfield Clinic, 1000 N Oak Ave, Marshfield, Wis 54449 (phone: 715/387-5351). Copyright 1981 by the State Medical Society of Wisconsin.

Other caucus recommendations included increased research and education in the care of the special diseases of aging with more adequate dissemination of available information.

A community options program for disabled and elderly persons is proposed for Wisconsin beginning in calendar year 1982. Initially eight target counties will be involved in more comprehensive planning for the elderly patient with a threatened loss of autonomy. Patients who otherwise would have been placed in nursing homes will have community options developed to more comprehensively deal with individual needs. In calendar year 1983 additional counties with at least 70% of the state's nursing home population will be required to participate.

My impression as a participant in this conference was that many delegates were quite concerned about the cost and means of delivery of medical care. Their concerns have been passed on to Washington for the 1981 White House Conference. We, as the medical community, should consider these recommendations and acquaint ourselves with the changing medical economic picture dictated by the 80s. ■

WISCONSIN PSROs RANKED HIGH, LOW. Wisconsin's Professional Standards Review Organizations (PSROs) ranked high and low in a national ranking of performance levels conducted by the US Dept of Health and Human Services (HHS). HHS conducted the evaluation to (1) identify PSROs that failed to meet minimum program performance requirements, and (2) develop a performance-based ranking to be used if budget support for the PSRO program is reduced by Congress. The Wisconsin Professional Review Organization (WisPRO) received 2037 points out of a possible 2350 ranking 13th out of the nation's 182 PSROs. The Foundation for Medical Care Evaluation in Southeastern Wisconsin (FMCE) was ranked 124th. ■

'STRAIGHT DOPE ON MARIJUANA'. Want your patients, your children, and others to learn the true facts about marijuana and its hazards? Then order a new brochure recently prepared by the SMS Commission on Public Information entitled *Straight Dope on Marijuana.* Developed at the request of the SMS Board of Directors, the brochure explains what marijuana is, who uses it, and its harmful effects on behavior, performance, and functioning of various organ systems. Membership in SMS entitles physicians to 200 free copies for use in their offices. Additional copies are available at a cost of $4 per 100. ■

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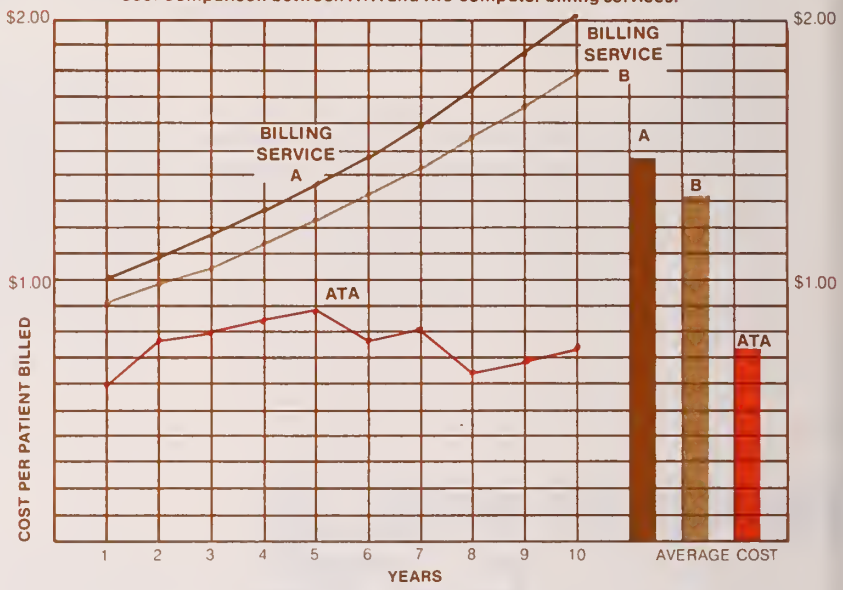

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NUTRITION

Wisconsin nutrition at Harvard . . .

Fredrick J Stare, PhD, MD, Boston, Massachusetts

On July 1, 1942 a small bit of Wisconsin's nutrition took up residence in the form of a new department in the schools of medicine and public health of Harvard University. It was then that I, along with Doctors DM Hegsted and John McKibbin, started this department. We were all products of the Department of Agricultural Biochemistry of the University of Wisconsin at Madison.

I received my BS, MS, and PhD degrees (the latter in 1934). One of my pieces of luck, and there have been several, is that I was the first student of the late Professor Conrad E Elvehjem—the first to do a Bachelor's thesis under his direction, and the same applies to the other two degrees. After three years as a postdoctorate fellow of the Rockefeller Foundation, two of which were spent in Europe (more luck), I returned to Madison and with Dr Harold Rusch was one of the first two employees of the Bowman Cancer Research Laboratory which later became the McArdle Cancer Research Institute. After two years as a Research Associate in Biochemistry, I went to medical school at the University of Chicago and then on to Barnes Hospital, St Louis, Missouri for an internship in medicine.

One Saturday afternoon in December 1941, I received a letter from Dr A Baird Hastings, then professor and chairman of the Department of Biochemistry at the Harvard Medical School, stating that Harvard had recently received a generous grant from the Rockefeller Foundation to set up a new department of nutrition, jointly between the schools of medicine and public health, and I was one of several individuals they would like to interview about the position. After three trips to Boston and two seminars at Harvard, I was selected (more luck).

Now, whom could I get to help me? I naturally turned to Connie Elvehjem for advice, and he suggested I consider Mark Hegsted and Jack McKibbin who had recently received PhD degrees in nutritional biochemistry from Madison. They were both interested, so we all arrived in Boston and showed up for work July 1, 1942—I as an Assistant Professor of Nutrition and Head of the new department, and Mark and Jack as Research Associates. We also started with a pretty blonde secretary, Betty Heimark, who had just graduated in biology from Mount Holyoke. The best we could say for Betty relative to Wisconsin was that she came from Minnesota.

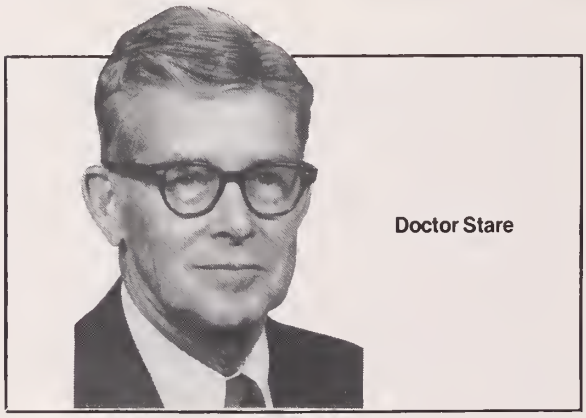
Nineteen forty-two (1942) was the first year of the Second World War for our country, and most academic research laboratories soon turned their attention to war-related problems. With us we tried to find out whether malaria was in any way affected by nutritional status. The experimental animal used was the duck. The usual experimental animals—rodents—do not get malaria. We could find no evidence that nutritional deficiencies or supplements in any way influenced the course of malaria (in the duck).

Another war-related problem was to improve intravenous nutrition, specifically to prepare emulsions of fat that could be given by vein so one might provide adequate calories for those who cannot be fed orally. Here, we had considerable success. About this time (1945), Doctor McKibbin left us to join the Department of Biochemistry at the University Medical School of Alabama in Birmingham. To replace Jack, I secured the services of another Wisconsin product, Robert P Geyer who had recently received his PhD in nutritional biochemistry. Doctor Geyer continued our researches on fat emulsions and then started researches on what we commonly call "synthetic blood"—emulsions of compounds called fluorocarbons which have the capacity of absorbing and releasing oxygen and carbon dioxide. Bob has become a leader in this im-

Doctor Stare is Professor of Nutrition, Emeritus, Harvard University School of Public Health, Department of Nutrition, Boston, Massachusetts. Reprints of the nutrition articles may be obtained upon request to: *Wisconsin Medical Journal,* PO Box 1109, Madison, Wisconsin 53701. Copyright 1981 by the State Medical Society of Wisconsin.

portant area of medical-nutritional research and he has prepared for this issue a brief resume of his researches in this area. Incidentally when I had to retire as department chairman (June 30, 1976) because of Harvard's regulations, Bob became departmental chairman, a post he still holds and one in which he does well.

After the Second World War, I turned my own attention to a variety of nutritional problems associated with coronary heart disease, specifically the role of diet in influencing atherosclerosis. We were the first laboratory to utilize subhuman primates (monkeys) as an experimental animal for this important medical problem. One of the key papers from the department was "Experimental Atherosclerosis in Cebus Monkeys," published in the *Journal of Experimental Medicine* in 1953 (Vol 98, pp 195-218).



Doctor Stare

It is usually a surprise to most cardiologists that the cardioverter, in such common use today, was developed many years ago in our laboratories by the internationally respected cardiologist, Dr Bernard Lown, who has been for many years, and still is, a member of Harvard's Department of Nutrition with the title of Professor of Cardiology in Public Health.

In addition to many, many research studies in the cardiovascular-atherosclerotic-nutrition area utilizing monkeys, rats, dogs, and man, the department has been active in the preparation of practical information for well people, patients, and physicians. In fact, the first statement from the American Heart Association on diet and heart disease was released in 1952 under the title of "Food For Your Heart—a Manual for Patient and Physician" and it was prepared by several of us in Harvard's Department of Nutrition. Interestingly, it stressed "prevention or treatment of overweight or obesity, and early treatment of hypertension," and it stated, "the fundamental rules of good nutrition are these: first, eat a variety of foods; second, maintain your desirable weight."

Getting back to Wisconsinites in nutrition at Harvard, the late Martha Trulson of Stoughton who received her BS degree from Madison came to us for her doctorate degree in nutrition, became a staff member, and rose rapidly to the rank of Associate Professor before her unfortunate death. She was responsible for starting many of our researches on obesity, and she organized and participated in our well-known Irish Brothers research study.

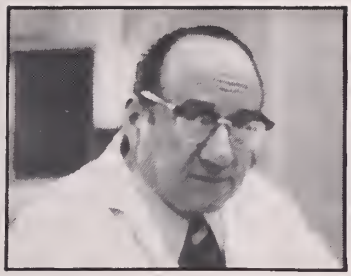
Next from Wisconsin came Stanley Gershoff who received his PhD from Madison in 1951. Stan is well known for his researches on the nutrition of cats, on vitamin B_6, and on the iron needs of the elderly. He left us a few years ago to become a Professor of Nutrition at Tufts Medical School and director of the Tufts Nutrition Institute. He has also prepared a brief paper for this issue.

Nutrition at Harvard has grown rapidly since this Wisconsin satellite began in 1942. From four people on the payroll in 1942 and two students, we grew rapidly until by 1960 we had "some" 150 people and 15 to 20 students. Many of our graduates occupy key positions in nutrition, public health, and medicine in many parts of this country and the world, for example: Jack Metcoff, MD, Professor and Chairman of Pediatrics at Oklahoma; William Wadell, MD, Professor and Chairman, Department of Surgery at Denver; TB Van Itallie, MD, Professor of Medicine at Columbia University and Head of the Department of Medicine, St Luke's Hospital, New York; JJ Vitale, DSc, Professor of Nutrition, School of Medicine, Boston University; Robert E Olson, PhD, MD, Professor of Medicine and Biochemistry and Head of the Department of Biochemistry, St Louis University School of Medicine; and Dr Louis Fillios, DSc, Professor of Nutrition at Boston University School of Dental Medicine, are examples of former students from this department.

We still turn occasionally to Madison for some new blood. The latest addition being Dr Renny Franceschi, an Assistant Professor of Biochemistry who recently was a postdoctorate fellow under one of Wisconsin's nutritional greats, Dr Hector DeLuca.

My main associate for the first 37 years of the existence of Wisconsin Nutrition at Harvard was Dr DM Hegsted who joined me at the beginning, one year after receiving his PhD in nutritional biochemistry. Doctor Hegsted rose rapidly from research associate to full professor. His researches have been many, including improvements in evaluating the nutritive quality of proteins, protein requirements of man, factors influencing the absorption of iron, and many of our pioneering studies on comparative nutrition, particularly those involving subhuman primates (monkeys). Doctor Hegsted left the department a few years ago to become director of the Human Nutrition activities of the Department of Agriculture.

So, perhaps you will agree, Harvard has done well with nutrition from Wisconsin; even my present research assistant, Elizabeth Hubbard, graduated from Madison in 1975. No, we are not prejudicial, we just look for the best! ■



Doctor Geyer

More Wisconsin nutrition at Harvard. . .

Robert P Geyer, PhD, Boston, Massachusetts

A FEW MONTHS AFTER receiving my PhD from Wisconsin in 1946, I followed two other Wisconsin PhDs to Harvard to join Dr Fredrick Stare in developing Harvard's Department of Nutrition. At that time, and for the preceding few years, Doctor Stare and Dr Jack McKibbin had been developing emulsions of fat that could be administered intravenously as a means of supplying generous quantities of calories to the patients who had to be fed by vein. When Doctor McKibben left the department, Doctor Stare assigned that problem to me.

Our first paper on what was the beginning of the current interest in total parenteral nutrition was published in 1945 under the title of Parenteral Nutrition 1. Studies on Fat Emulsions for Intravenous Alimentation (*Journal of Laboratory and Clinical Medicine* 30:488-497, 1945). One of our last papers on this subject was published in 1957 under the title of "Clinical Observations on the Use of Nonphosphatide (Pluronic) Fat Emulsions." (*Metabolism* 6:815-821, 1957).

During many of the 12 to 15 years we were doing this pioneer research on fat emulsions for intravenous nutrition, we had the collaboration of many colleagues and the support from both industry and government. Because of a minor problem in meeting Food and Drug Administration requirements, marketing of the preparation was delayed. A decision was made to withdraw the product, and with that went most of our support for this research.

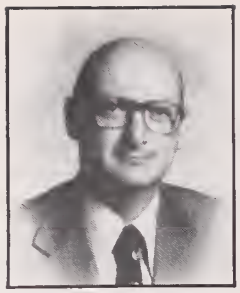
We then directed these research interests to the development and use of artificial preparations for partial or total blood replacement. The most successful of these products utilize emulsified perfluorochemicals, compounds that are biologically and chemically inert but dissolve large quantities of oxygen and carbon dioxide. These emulsion particles are a fraction of the size of the red cells they replace. Hydroxyethylstarch is used to furnish colloid osmotic pressure that is ordinarily contributed by the plasma proteins. Electrolytes and some other small molecules make up the remainder of the preparations. After being sterilized, the material can be used to replace *all* of the blood of animals while they breathe a somewhat elevated O_2 atmosphere. They remain in good condition, behave normally, and replace their missing red cells and plasma proteins. They are also protected against carbon monoxide poisoning while circulating the perfluorochemicals. A preparation of this type is being used with success in early clinical studies in this country and Japan when blood cannot or will not be used. The perfluorochemical preparations have many other important potential uses ranging from organ preservation to better oxygenation of ischemic hearts *in vivo*. A long-time goal of this research is to achieve preparations that are well tolerated and that eventually will carry sufficient oxygen to support life in ambient atmospheres.

In other research we are investigating the metabolic effects of a new mitogenic peptide found in human platelets. This is an extremely active substance that stimulates the division of human diploid cells. Amino acid uptake by the cells is also accelerated. The relationship of these changes to DNA synthesis is being studied. This peptide is believed to be involved in the development of atherosclerotic plaques. Platelets are thought to adhere to damaged vascular endothelial areas and release the peptide which then causes arterial smooth muscle cells to multiply and cause thickening of the arterial wall. Determining the effects of this compound can contribute to the understanding of atherogenesis.

Still other research is directed towards the possible role of serum albumin-lipid complexes in cholesterol metabolism and transport. These studies involve animal and human cells *in vitro*. Of considerable interest is the fact that complexes containing saturated phospholipids have a pronounced influence on cholesterol movement into and out of cells, whereas phospholipids containing polyunsaturated fatty acid moieties have little effect. From detailed chemical and biological studies we have shown the complex effect is independent of lipoproteins. Furthermore, the structural requirements (after studying many phospholipids) show that such complexes are highly specific and that the phenomenon is not the result of random phospholipid-albumin binding. The possible role of these complexes *in vivo* is under study.

In another research project the marked intestinal mucosal cell lipodystrophy in female gerbils brought about by inositol deficiency is being studied. The findings suggest that the defect is related to either chylomicron formation by the cells or to a lack of transport from the cells. Current work with *in vitro* systems is directed to elucidate the enzyme(s) involved in this phenomenon. ■

Doctor Geyer is Professor of Nutrition and Chairman of the Department of Nutrition, Harvard University School of Public Health, Boston, Massachusetts 02115. Copyright 1981 by the State Medical Society of Wisconsin.



Doctor Gershoff

Cats and stones. . .

Stanley N Gershoff, PhD, Medford, Massachusetts

WITH BA, MS, and PhD degrees from Wisconsin in nutritional biochemistry, it is obvious that I am a product of Madison. I left the Department of Biochemistry at the University of Wisconsin in 1952 to join the staff of the Department of Nutrition at the Harvard School of Public Health as a postdoctoral fellow, and never in the years that have passed have I regretted that decision. The attraction of the Harvard Department of Nutrition, which Frank Lloyd Wright might have called Wisconsin East, was that I could not only continue my research in the field of biochemistry, but the orientation of the school was such that the work that I did and the work that my colleagues did almost invariably had a short- or long-term application to the health needs of man and animals.

When I first arrived in Boston, Dr Fredrick Stare suggested that I work on studies having to do with the vitamin metabolism of mongoloid and other retarded children. At the same time we instituted a series of studies of the nutritional requirements of cats. As often happens in research, the unexpected occurred. The cat studies proved to be considerably more important to the direction of my future work. In our study of the vitamin B_6 requirements of cats, we found that the deficiency was accompanied by the deposition of oxalate crystals in the kidneys of the animals. The histologic pattern resembled a relatively rare but fatal disease of man called oxalosis. Shortly thereafter, using a vitamin B_6-deficient rat model, we were able to develop calcium oxalate kidney stones similar in composition to those most often seen in human kidney stone disease.

Our renal and vesical stone work has continued; and during the past 20 years, it has involved people in various parts of the world. A major application that has come from these studies is an effective means of preventing new stone formation with magnesium in patients with histories of recurrent calcium oxalate nephrocalcinosis. In the April 1981 issue of the *American Journal of Clinical Nutrition,* we described the production of bladder tumors in rats by dietary means without the use of carcinogens.

Throughout the years, our studies have varied enormously ranging from conventional nutritional biochemical studies to others which involve endocrinology and immunology. One of the delights in working in a major biomedical center such as Boston, is that if one has good ideas, people can usually be found with whom to collaborate. About 15 years ago I became concerned about what I perceived to be nutrition problems of Americans, particularly poor Americans. Until that time most of our studies had been done in animals; and when they involved human subjects, they were usually individuals who had metabolic or other disease problems, or were inhabitants of developing countries. In the late 1960s I collaborated with a group of people in producing a book called "Hunger, USA." This pointed out that there were many counties in America in which more than 50% of the people lived below the poverty line and in which there were no federal feeding programs. While most of these counties were in the deep south, interestingly, two were in the Green Bay, Wisconsin area. The publication of "Hunger, USA" resulted in different reactions in different parts of the country. In some places it was considered to be the work of a group of troublemakers. However, in Wisconsin the reaction was quite different. The legislators representing the counties involved were besieged with calls, telegrams, and letters. In Wisconsin, America's dairyland, it was not acceptable that people go hungry.

The stir caused by "Hunger, USA" and a variety of other events which occurred about that time, resulted in President Nixon's convening a White House Conference on Food, Nutrition and Health. Harvard's Department of Nutrition played a major role in that conference. Dr Jean Mayer, then a Professor of Nutrition in the Harvard department, was the chairman of the conference, and I was in charge of the panel which had to do with the federal food programs. A number of other members of our department were involved in positions of responsibilities related to this conference. The results of that conference were longlasting and in great part were responsible for the many excellent domestic food programs which were developed in the past ten years. During the 1970s there arose in various parts of our government, the feeling that many nutritional problems both at home and abroad could be solved by the fortification of foods with a few key nutrients. This was an interesting approach. The Department of Nutrition at Harvard responded to the need and conducted major field studies of the fortification of grains in different parts of the world. I was

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Doctor Gershoff was formerly Associate Professor of Nutrition at Harvard University School of Public Health and currently is Dean of the School of Nutrition, Tufts University, Medford, Massachusetts 02155.
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responsible for a program involving fortification of rice in Thailand. In addition, I also studied the effects of iron fortification on moderately anemic elderly people in the United States.

In general, the results of the fortification studies were disappointing. While some people might view them as being failures from the public health point of view, it seems to me that they were quite successful. They clearly exposed our lack of basic knowledge concerning the etiology of much of the malnutrition seen in the world, and they demonstrated the need to do field studies before setting forth programs which might cost hundreds of millions of dollars. Unfortunately, the retirement of Doctor Stare as Chairman of the Department of Nutrition at Harvard in 1976 coincided with the appointment of a new Dean. Since then it has become increasingly apparent that the approach of the administration of the Harvard School of Public Health to public health has become very much different than it had been in the past. When Jean Mayer left Harvard to become President of Tufts University four years ago, a number of biomedical and social scientists in nutrition at Harvard and the Massachusetts Institute of Technology, including myself, decided to join him.

Over the years my colleagues and students have commented on the fact that somebody with as short a fuse as I have can be patient with students. What they do not understand is that this is the only way I can ever pay back the wonderful professors in the Wisconsin biochemistry department (Elvehjem, Hart, Baumann, Link, Phillips, Snell, Peterson, Steenbock, and Lardy) for all they did for me. ■

Mechanism of action of Vitamin D

Renny T Franceschi, PhD, Boston, Massachusetts

Doctor Franceschi

VITAMIN D RESEARCH has a long and outstanding history at the University of Wisconsin-Madison beginning with EV McCollum who first reported the existence of a vitamin necessary for growth in 1913. This was followed by the now famous studies by Steenbock and Black published in 1924 which demonstrated that antirachitic activity could be generated by irradiating foods such as milk, bread, meats, and butter. This discovery led to the eventual elimination of rickets as a major medical problem in the Western world.

The second major milestone in the field also occurred in Madison: the discovery by Hector DeLuca and coworkers that Vitamin D_3 is actually the precursor to a family of metabolites, one of which, 1,25-dihydroxyvitamin D_3 is the hormonally active form capable of stimulating the absorption of calcium and phosphate by the intestine and bone mineral mobilization. The isolation and identification of the various Vitamin D metabolites has been an enormously productive research area over the past 15 years and continues to be led by the DeLuca group.

In recent years a considerable effort has been directed toward understanding the mechanism of action of 1,25-dihydroxyvitamin D_3. Much evidence (again, a good deal coming from Madison) has accumulated over the past decade suggesting that this compound may act much like a classic steroid hormone. That is to say, 1,25-dihydroxyvitamin D_3 in complex with a specific receptor protein interacts with the cell nucleus where it stimulates the expression of genes controlling calcium and phosphate absorption.

While a postdoctoral fellow with Doctor DeLuca at Madison, I was involved in several investigations related to the mechanism of action of 1,25-dihydroxyvitamin D_3 in intestine. I studied several properties of the cytoplasmic receptor for this hormone and also demonstrated that hormone-dependent calcium transport could be blocked by inhibitors of protein and RNA synthesis in cultured intestinal cells. This latter result is a further piece of evidence arguing that 1,25-dihydroxyvitamin D_3 acts by stimulating new gene expression.

As the most recent Wisconsin-reared addition to the Harvard Nutrition faculty, I hope to continue studies on the mechanism of action of 1,25-dihydroxyvitamin D_3. I am particularly interested in identifying intestinal brush border proteins induced by this hormone and determining their role in calcium transport.

Living up to the Wisconsin tradition that has preceded me will be no easy task. ■

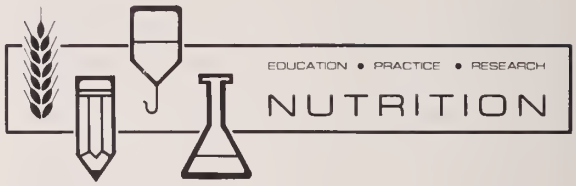
Doctor Franceschi is Assistant Professor of Biochemistry in Nutrition, Department of Nutrition, Harvard University School of Public Health, Boston, Massachusetts 02115. Copyright 1981 by the State Medical Society of Wisconsin.

Megavitamins. . .

Fredrick J Stare, PhD, MD, Boston, Massachusetts

To close this series of reports about Wisconsin nutrition at Harvard, your editor has asked that I prepare a brief comment about the current interest in megavitamins. This I am pleased to do because one of my interests for many years has been exposing nutritional nonsense, regardless from where it comes.

* * *



MEDICAL RIP-OFFS have existed in this country since the days of the traveling medicine shows. Now, however, health quackery has become "big business," costing Americans an estimated billion dollars a year. Added to this is the price these victims pay in suffering and false hopes, as well as in the delay of effective medical treatment. Medical quackery can be an expensive, dangerous, even deadly practice.

Currently one of the most popular—and dangerous—forms of medical charlatanism is megavitamin therapy. The philosophy behind this new form of quackery is simply: if a small dose of a vitamin is good, then a large dose must be even better, and an enormous dose is stupendous. In reality, a moderate amount of vitamins, like a moderate amount of all nutrients and of food in general, is necessary for health and well-being. And, like anything else, too little is definitely not enough, but too much is certainly not desirable either.

Megavitamin promoters advocate large doses of specific vitamins for a long list of health problems ranging from bad breath and brittle nails to heart disease and cancer. Because these claims instill hope for optimal health, cure of illness, and prolonged life, megavitamin salesmen are quite successful in their efforts. In fact, a recent national survey of our adult population revealed that 75 percent think that extra vitamins will provide pep and energy, and lead to better health.

The success of medical hucksters is partly due to the fact that they have developed a firm understanding of the fears and superstitions of their potential victims, and therefore are able to offer some very specific and often quite scientific-sounding methods for dealing with them. Medical quacks can also thank the media to some degree for their current success in reaching the confused public: newspapers, magazines, radio, and television all seize upon the latest nutritional claim and immediately feed it to the gullible public audience, usually in any aura of sensationalism akin to that utilized by the *National Enquirer*. Unfortunately, consumers are only too willing to gobble it up, despite potential damages to both financial status and overall state of health.

The dangers associated with megavitamin usage are fairly well documented for certain vitamins, while the side effects of megadosing with other vitamins are as yet less understood. Consumers should realize, however, that by taking large doses of vitamins they are, in effect, taking part in an uncontrolled experiment. Personally, I'd prefer to have laboratory animals undertake our share of megavitamin research.

Vitamins, like any ingested substance, can be toxic if taken in excessive amounts. Vitamin A overdose can produce anorexia, growth retardation in children, drying and cracking of the skin, irritability, liver and spleen disorders, severe headaches, increased intracranial pressure, and bone and joint pain. Prolonged intake of excessive quantities of vitamin D can cause anorexia, weakness, nausea, weight loss, polyuria, constipation, vague aches, stiffness, calcification of tissues and organs, hypertension, hypercalcemia, acidosis, irreversible renal failure, and death.

"Orthomolecular psychiatry," which promotes megadoses of niacin derivatives to treat mental disorders, frequently results in flushing, itching, and may lead to liver damage, dermatoses, elevated blood glucose, gouty arthritis, and peptic ulcers.

Large doses of other B vitamins may also cause undesirable side effects. Vitamin C megadoses can adversely affect growing bones, plus cause renal problems, diarrhea, false laboratory test results, and "rebound scurvy" in which the user develops the symptoms of scurvy upon cessation of the excessive intake. Pregnant women who take massive doses of vitamin C can develop menstrual bleeding, and their offspring may suffer from rebound scurvy as well.

Some of the possible side effects of megadoses of Vitamin E include headaches, nausea, fatigue, blurred vision, reduced gonadal function (which belies the myth that vitamin E heightens sexual potency), inflammation of the mouth, chapped lips, gastrointestinal disturbances, muscle weakness, low blood sugar, and increased bleeding tendency. All this suffering, and to no avail—vitamin E in massive doses or even in small doses above those present in our diets—has yet to be shown as effective treatment for anything!

There is no need for added vitamins when eating a well-balanced diet. And there is no evidence to support the use of megadoses of vitamins, either for treatment of illness or to promote good health. In fact, any so-called "evidence" used to support megavitamin claims is usually based on testimonials,

anecdotes, and slip-shod "studies." Despite the vociferous claims to the contrary made by megavitamin enthusiasts and vitamin salespeople, this type of evidence is misleading and basically worthless.

Megavitamins are unnecessary, expensive, useless, and potentially dangerous—really meganonsense! And it is the unwary consumers, misled by the false promises of megarip-offs, who ultimately lose out—both monetarily and healthwise—in the end.

For those interested in more detailed comments, attention is called to two recent excellent books on the subject:

THE HEALTH ROBBERS, by Steven Barrett and Gilda Knight, GF Stickley Co, 1980.

NUTRITION CULTISM—FACTS AND FICTIONS, by Victor Herbert, GF Stickley Co, 1980. ■

Nutrition controversies. . .

Alfred E Harper, PhD, Madison, Wisconsin

CURRENT NUTRITION controversies center mainly around relationships between diet—particularly the quantities of sugar, fat, cholesterol, fiber, and sodium in the diet—and the incidence of various chronic and degenerative diseases, especially heart disease, cancer, and stroke. In 1978 the Select Committee on Nutrition and Human Needs of the US Senate concluded that changes in the diets of Americans since 1900 "amount to a wave of malnutrition that may be as profoundly damaging to the Nation's health as the widespread contagious diseases of the early part of the century".[1] Yet, just one year later, the Surgeon General issued a report[2] which began "The health of the American people has never been better." The authors attributed this, in large measure, to improvements in nutrition and sanitation since the turn of the century. These two statements illustrate the differences in opinion about relationships between diet and disease that lie at the heart of current nutrition controversies.

In order to place controversies over any aspect of health care in perspective, they must be viewed in relation to the changes in health that have occurred over the years.[3] In 1900 most deaths in the United States were from a wide variety of infectious diseases; malnutrition, particularly among the very young, was an important health problem. Of those born less than 40% lived to reach 65 years of age. Nevertheless, even then, cardiovascular disease was the largest single cause of death. Cancer ranked seventh.

During the next 50 years, as scientific knowledge of nutrition grew and was applied in medical and public health practice, nutritional deficiency diseases were all but eliminated. Also during this period, through better nutrition, improved sanitation, especially of food and water, and progress in immunization and antibiotic therapy, most infectious diseases were brought under control. As a result of these and other advances in medical care, more than 70% of those born now live to age 65 or beyond, and life expectancy at birth has increased from 47 to 72 years. The major causes of death and disability among those between the ages of one and 45 are accidents and other forms of violence.[4] This pattern of change in health status fully justifies the statement in the Surgeon General's Report that "health. . .has never been better." This could not have occurred if the changes in diet over the years had amounted "to a wave of malnutrition."

These improvements in nutrition and health have been accompanied by remarkable changes in the age distribution within the population and in the major causes of death. People age 65 or over now represent 11% of the US population instead of the 4% they did in 1900.[5] Chronic and degenerative diseases have become the major medical problems and two-thirds of all deaths are now from cardiovascular diseases and cancers. Inability to identify the causes of these diseases, and the limited effectiveness of current treatments for them, have given rise to speculations that changes in diet are responsible for the increased incidence of chronic and degenerative diseases. It seems rarely to be recognized that increased incidence of most of these diseases can be attributed to the increase in the proportion of elderly people in the population.

Despite the fact that improved nutrition has contributed importantly in enabling so many people to live long enough to develop such diseases, the successes that have been achieved in preventing nutritional deficiency and infectious diseases have raised the hope that chronic and degenerative diseases can also be prevented by diet modification or some other simple expedient. Three types of evidence have been marshalled in support of these speculations. First, epidemiologic studies have revealed that the incidence of chronic and degenerative diseases is usually highest in countries with a high standard of living where sugar, fat, cholesterol, and sodium intakes are high and starch and fiber intakes are low. Second, metabolic problems associated with some of these diseases can be relieved, in part at least, by diet therapy. Third, it has been possible by modifying the carbohydrate, fat, cholesterol, fiber or sodium content of the diets of animals

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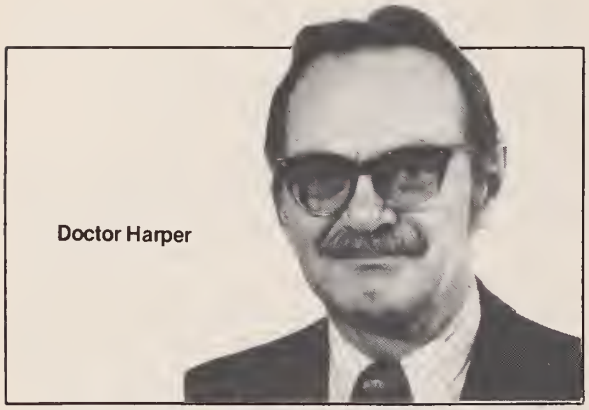
to produce or ameliorate blood and tissue changes resembling those associated with certain chronic and degenerative diseases. Extrapolation from such observations has led to the assumption that the incidence of hypertension, arteriosclerosis, stroke, cancer, and diabetes could be reduced if Americans would make moderate changes in the salt, fat, cholesterol, sugar, and fiber content of their diets. A report by the American Society for Clinical Nutrition[6] provides much information on this subject.



Doctor Harper

There is perhaps less controversy and greater knowledge about the relationship between salt intake and hypertension than about most of the other postulated relationships between diet and disease. Also, the controversy over what is appropriate salt intake in view of the current state of knowledge illustrates well the nature of problems that are encountered in dealing with other nutrition controversies. Therefore, I shall discuss it first.

The following relationships are usually cited as the basis for recommendations for a reduction in salt intake as a means of reducing the incidence of hypertension. Somewhere between 10% and 20% of the US population develops hypertension. Groups who live in isolated environments where salt intake is about 2 gm per day do not develop hypertension. Restriction of salt intake lowers blood pressure in a proportion of those with hypertension. The incidence of hypertension is high among people in areas where salt intake exceeds 20 to 25 gm per day.[7] The controversy arises, not so much over the reliability of the available information, but rather over what is the appropriate recommendation for the public in view of this information and how effective any dietary recommendation will be in reducing the incidence of hypertension. Many of the complexities of hypertension receive little consideration in relation to nutritional judgments.

Those who accept the view of the Senate Select Committee conclude that the appropriate approach to control of hypertension is to recommend that the entire population restrict salt intake to 5 gm or 3 gm or less per day and that every effort be made, by Federal regulation if necessary, to reduce the salt content of the food supply. As an alternative to this extreme approach, the Food and Nutrition Board, among others, recommended moderation in the use of salt and proposed that an appropriate range for salt intake was from 3 to 8 gm per day.[7,8] Close to 85% of the population tolerates a salt intake of 10 to 12 gm without developing hypertension. The lower end of the recommended range represents salt restriction; it is appropriate for those who have, or who are known to be susceptible to, hypertension. The upper end of the range is below the average consumption in the US but, as salt is ordinarily consumed in amounts greatly in excess of need, and as consumption of excessive amounts of individual nutrients cannot be shown to confer unique benefits, this general reduction is proposed on principle. It was not proposed with any assurance that following it would reduce the incidence of hypertension. It was realized, however, that moderation of salt intake may enable many of those who depend on drugs for control of hypertension to reduce the dose they would need to lower their blood pressure. The controversy, it is evident, is not so much a scientific controversy as it is a public policy controversy over what should be done about a complex problem for which there is no simple answer. The same is true for most other nutrition controversies.

The greatest controversy of all is over recommendations for modifying fat and cholesterol consumption as a means of reducing the incidence of heart disease.[6] Elevated concentrations of serum cholesterol and low density lipoproteins are among the 30 or more risk factors for heart disease.[9] Associations between cholesterol, total fat and saturated fat intakes, and the incidence of heart disease have been demonstrated in epidemiologic studies, but exceptions to these relationships are observed and remain unexplained. Trials in which large numbers of men have been treated with drugs or by diet modification in an effort to reduce serum cholesterol concentration and the incidence of heart disease have resulted, at best, in modest decreases in the incidence of the disease and in negligible decreases in overall death rate. It is possible to lower serum cholesterol concentration by 12% to 15% in carefully controlled clinical trials by substituting polyunsaturated for saturated fat in the diet but effects have been much smaller in free-living populations. In animal studies, species differ greatly in their responses to dietary manipulation and usually the diet modifications required to develop an animal model for studying effects of diet on serum cholesterol concentration are extreme. Also, many dietary factors besides fat and cholesterol have been found to influence serum cholesterol concentration in animals.[10] There is little evidence of an association between dietary cholesterol intake and serum cholesterol concentration in men except for those at the extreme ends of the range. Recently there have been reports of an elevated cancer incidence among men with low serum

cholesterol. Even ardent proponents of diet modification concede that diet is one of the lesser risk factors for heart disease.

It is an insurmountable problem to assess the practical significance of the mass of information that bears on the subject of diet and heart disease, especially when half of those who suffer coronary attacks do not have a clearly identifiable pattern of risk factors.[11] Nevertheless, there is no dispute, even among groups with divergent views on the overall effectiveness of diet modification, that for those who are identified as being at risk of heart disease, management of their problem should focus on reducing all identified risk factors. On the other hand, there is great controversy over recommendations for the general public. The Food and Nutrition Board's Committee on Dietary Allowances concluded that it was not desirable to make a blanket recommendation for dietary change for the entire population.[8] The Board itself concurred.[7] It was not satisfied that the scientific information about cholesterol consumption and the incidence of heart disease was definitive, nor that a general recommendation about fat consumption could be justified. It concluded that variety in food selection and moderation in total caloric intake to maintain appropriate body weight were, as they have been for decades, the basic keys to a healthful diet. These conclusions are in accord with those of the American Medical Association.[12] They diverge from those of the American Heart Association which has proposed specific reductions in fat, saturated fat and cholesterol and an increase in polyunsaturated fat consumption for the general public.[13]

The controversy over sugar is largely emotional. Claims that a high sugar intake contributes to the development of diabetes and cardiovascular disease have not been substantiated, nor has the claim that obesity is the result of a high sugar intake. Obesity is the result of high total caloric intake—usually from whatever type of diet the obese individual finds desirable. Sticky, sugary products, however, especially when eaten between meals, do contribute to the development of dental caries.[6]

Sugar is a constituent of many desirable foods such as fruits and vegetables. Consumed by itself, it is a perfectly acceptable source of calories but a poor source of essential nutrients. Those who are inactive and whose caloric needs are low must select foods that are rich in essential nutrients in order to meet their other nutritional needs. They should consume highly refined products that are poor sources of essential nutrients sparingly. However, this applies not only to sugar but also to highly refined starches, fats, and oils.[6,7]

Fiber is the "nutrient" of the decade. It has long been recognized that a moderate intake of fiber, or "bulk" as it was called 50 or more years ago, eases the evacuation of wastes by increasing the water content of the residue in the colon. More recently, reports that heart disease, diabetes, obesity, colon cancer, and various gastrointestinal diseases are rare among rural Africans who eat high fiber diets have become the basis for exaggerated and unsubstantiated claims that these diseases are the result of a low fiber intake. Nevertheless, these claims have renewed interest in the possible beneficial effects of fiber and have stimulated much research on relationships between fiber intake and many diseases.[15]

A high starch, moderate fiber diet has been shown to improve blood glucose control in adult (non-insulin dependent) diabetes. Fiber is claimed to be beneficial for the prevention of diverticular disease. Some types of fiber are reported to lower serum cholesterol concentration, and also to reduce the incidence of colon cancer in animals fed carcinogens. The significance of most of these observations for the treatment and prevention of human disease, while tantalizing, is far from established. In addition, fiber in foods is not a single substance, it is a complex of many substances that differ considerably in their physical and chemical properties and in their physiological effects. Excessive fiber intake can cause severe gastrointestinal distress. Also, fiber can bind mineral elements and reduce their absorbability. There is no acceptable rationale for recommending high intakes of refined and purified sources of fiber to the public generally. On the other hand, a recommendation for a moderate intake of fiber from fruits, vegetables, and cereal grain products, as a means of ensuring normal intestinal function, has a sound physiological basis.[15]

> ***"We do not have. . .protection against the false health claims for foods and nutrients made in articles and books, sometimes even by physicians and scientists. . .It is. . .essential that we be on our guard and most skeptical when we encounter simple nutritional solutions for what we know to be complex health problems."***

Claims are widespread that high intakes of individual essential nutrients or consumption of specific foods have unique disease-preventing or health-promoting properties. These claims are reminiscent of those of the pre-scientific era in medicine when foods were endowed with magical properties. We have learned that there are no unique "health foods" and that excessive intakes of individual nutrients are not only without merit but also can be hazardous.[16] We demand, through government action, that food producers and pharmaceutical companies not be allowed to make unwarranted health claims for their products, either in their advertising or on their labels. We do not have such

protection against the false health claims for foods and nutrients made in articles and books, sometimes even by physicians and scientists. It is, therefore, essential that we be on our guard and most skeptical when we encounter simple nutritional solutions for what we know to be complex health problems.

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EDITORIAL

Impact on medicine. . .

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THE ENORMOUS IMPACT of Wisconsin nutrition and biochemistry on the field of medicine is rarely considered by the medical community in the State of Wisconsin. Consider that at the turn of the century, the concept of vitamins had not yet surfaced, and nutrition, as a science, did not exist. Biochemistry existed only in the hands of organic chemists of Europe. Interestingly enough, the entire field developed as a result of the large contributions by the University of Wisconsin, Department of Agricultural Chemistry, now called Biochemistry. This fledgling department, at the turn of the century, had only one member, Steven M Babcock, who was assigned the problem of solving agricultural problems through the use of chemistry. His first major contribution was to contribute a test to determine the butterfat content of milk attesting to the quality of milk deliveries. The Babcock butterfat test has been used because of its simplicity for many, many years.

Another important contribution of Professor Babcock was to recognize the talents of Professor E B Hart, who was brought in as Chairman of the Department of Agricultural Chemistry. Professor Hart, in turn, was a master, not only in carrying out research but also in recognizing talented individuals who were to make their mark in the field of nutrition and biochemistry. Among these brilliant young people were Harry Steenbock and Elmer V McCollum. A major assignment for the Department of Agricultural Chemistry was to determine why dairy cattle performed much better on certain rations made from corn than they did on rations made from wheat or oats, despite the fact all contained the same amount of digestible protein, carbohydrate, and fat. The Wisconsin Agricultural Biochemistry Department came to the conclusion that there were unknown micronutrients required for health and reproductive performance of the dairy cattle. This led Professor E B Hart to initiate a study on the dietary components required for health and development. This task was assigned to Elmer McCollum, who began using the small white rat as the investigative animal. He very soon demonstrated clearly the existence of a substance in butterfat and cod liver oil that was required for growth and for prevention of certain skin lesions called xerophthalmia. He was to name this subtance fat-soluble vitamine A, based on the concept of vital amines in the diet put forth

continued next page

Doctor DeLuca is Harry Steenbock Research Professor and Chairman of the Department of Biochemistry, University of Wisconsin-Madison.

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by Funk. It must, therefore, be recognized that the first true demonstration of a vitamin was at the University of Wisconsin, Department of Biochemistry, then called Agricultural Chemistry. McCollum was very quick to recognize that there was a water-soluble substance found in milk whey that he termed water-soluble vitamine B. These important developments with parallel developments at the Yale Experiment Station, under the direction of Osbourne and Mendel, put forth an explosion of the use of chemistry to elucidate the essential constituents of the diet. Wisconsin Department of Biochemistry was prominent in the continued development of vitamins and of nutrition in general.

Professor Steenbock next contributed the important discovery that carotene is the primary source of vitamin A from plant foods, and then subsequently demonstrated that irradiation of the fatty components of diet and of skin produce the antirachitic vitamin D substance. This discovery eliminated rickets as a major medical problem. Many other nutritional biochemical discoveries were made among the vitamins and in the minerals. For example, Elvehjem and Strong isolated and identified the antipellagra vitamin as niacin or nicotinic acid. This led to the elimination of pellagra as a major disease. Steenbock, Hart, and Elvehjem demonstrated the necessity of copper and iron in the diet for prevention of anemia. Professor E B Hart discovered the necessity of iodine in the diet for prevention of endemic goiter, and actually invented the iodized salt. Throughout the 1920s, 30s and 40s, the Department of Biochemistry in the College of Agricultural and Life Sciences at the University of Wisconsin provided the major training stage for most of the biochemists in the nation. Some 80 percent of all biochemists and nutritional scientists received their training at the University of Wisconsin, Department of Biochemistry. Among these trainees were some of the outstanding individuals, including Professors Stare, Gershoff, and Hegstad, who originated the School of Public Health in the Harvard Medical School. This Wisconsin transplant was highly successful as documented in these papers.

The Department of Biochemistry at Wisconsin is proud of the students who have come from its doors and have assumed positions of leadership in the biochemical and nutritional fields. The Harvard Medical School group is no exception. ■

EDITORIAL

Food and medical research

If one were presented with the problem of saving the most number of lives for a specific amount of dollars, the choice would not be medical research or improvements in healthcare delivery or in the technology of diagnosing and treating disease. The only logical purchase would be food for those who are starving. Strangely enough it would even affect some people in these 50 United States.

Too few people know the name of the person who received the Nobel Peace Prize in 1970. Certainly many are familiar with the name of Aledsankr Solzhenitsyn, Julius Axelrod, Bernard Katz, etc, but how many people remember Norman E Borlaug. Doctor Borlaug devoted his entire career to the development of more efficient high-yielding wheats. He successfully developed a dwarf wheat which would perform well under a variety of conditions, primarily in Mexico. These wheats are now grown successfully throughout a broad latitudinal range from Turkey to Paraguay, and supply a large amount of food for the Third World which was not available before the development of such wheat.

We all remember very well the Sabin Vaccine for the control of polio and the recent erradication of smallpox and what a "boon" these advances were for this and other developed countries. However, it is most likely that Doctor Borlaug has saved more lives in his research than any other single scientist since the institution of the Nobel Prizes.

I think it was most appropriate that this scientist received the Peace Prize in that famine often sparks anarchy and often results in conflicts which now can spread to consume not only the Third World but also the rest of the world. Doctor Borlaug and his accomplishments should be remembered and shown in a bright light as the investment of dollars in research such as this, viewed globally, produce a much greater return, affecting a vastly greater number of people.

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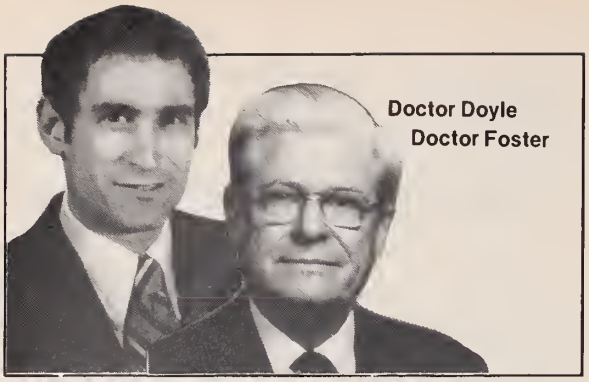

Bacterial agents of foodborne disease

Michael P Doyle, PhD and **Edwin M Foster, PhD**
Madison, Wisconsin

THE UNENDING CONTROVERSY over the presence of allegedly hazardous chemicals in our food supply has many people concerned and confused about the safety of what they eat. Adding to their bewilderment are scientists reporting conflicting data, consumer advocates airing nonfactual information, and faddists promoting organic foods. Such information has the befuddled consumer left wondering what foods are safe and wholesome.

However, such uncertainty does not exist over foodborne hazards of bacterial origin. Most everyone knows that when certain bacteria or their metabolites are present in food, consuming the food can make one sick. Anyone who has doubts will soon become a believer as symptoms of most bacterial-associated foodborne illnesses are expressed within a matter of hours to a few days after ingestion of the contaminated food. Fortunately, most types of bacterial food poisoning are short-term and produce only temporary discomfort; however, others such as botulism can be fatal.

Bacterial agents are responsible for most food poisonings attributable to microorganisms (Table 1). Information about such outbreaks is collected and published by the Centers for Disease Control (CDC) in Atlanta, Georgia. Annually CDC reports a few hundred confirmed outbreaks of foodborne disease with a few thousand cases per year; however, these figures hardly represent the true incidence of food poisoning in the United States. Informed sources estimate the number of such cases to approximate a few million per year.[1] Hence there is no doubt that foodborne diseases are of major consequence to the health of the American public.

For purposes of discussion, food poisoning agents of bacterial origin can be grouped into three categories: (a) those that grow in food and produce a toxin before the food is consumed; (b) those that are merely present as contaminants in food but initiate infection following ingestion; and (c) those that multiply and produce large numbers of vegetative cells in food, then release an enterotoxin in the gut. Reviewing some of the essential features of the major foodborne disease agents that comprise each of these categories may give one a better understanding and appreciation for real health hazards that can and do exist in our foods.

Intoxication—Ingestion of preformed toxin

Clostridium botulinum and *Staphylococcus aureus* organisms are most commonly associated with food poisonings due to ingestion of preformed toxins. *Clostridium botulinum* is responsible for botulism, the most feared of all foodborne diseases. Fortunately, less than 100 cases of botulinal food poisoning are reported in the United States each year (Table 1). In times past, over 50% of the individuals afflicted with botulism died; however, during the past decade the mortality rate has dropped to about 20%. This decline has been attributed to early diagnosis and improved supportive equipment.

The toxin of *C. botulinum* is one of the most potent poisons known to man. The human oral and lethal dose has been estimated from accidental cases of botulism to be between 0.1 and 1.0 μg.[2] The toxin blocks the passage of nerve stimuli, acetylcholine, at nerve endings and causes a bilateral neuromuscular weakness or paralysis.[3] The usual cause of death is respiratory failure. Diarrhea may precede the development of neuromuscular paralysis but constipation often develops as the illness progresses. Symptoms of disease usually appear within 12 to 36 hours after eating food that contains the toxin.

Eight antigenically distinct types of botulinal toxin have been identified. These are A, B,C_1, C_2, D, E, F, and G. Of these, types A, B, and E are responsible for most outbreaks of human food poisoning. In this country vegetables are more common vehicles of botulism than are meat and fish and home-prepared foods are more commonly implicated than commercially processed foods. Faulty home-canning practices, in which inadequate heat treatment allows botulinal spores to survive while killing less resistant competitors, is the most common cause of botulism in the United States.

Botulinal food poisoning is not a common disease because four distinct conditions must be met simultaneously before a hazard can exist:

From the Food Research Institute, University of Wisconsin-Madison, Department of Food Microbiology and Toxicology, Madison, Wisconsin 53706. Doctor Foster is Director of the Institute and Doctor Doyle is an Assistant Professor. Copyright 1981 by the State Medical Society of Wisconsin.

(1) Viable cells of spores of *C. botulinum* must be present in the food.

(2) The composition of the food must be suitable for growth of the organism; *ie,* the acidity must be greater than pH 4.6, the water activity above 0.93, and the atmosphere must be free of oxygen.

(3) The food must be stored long enough at a suitable temperature for growth and toxin production. Limiting temperature for production of types A and B is about 10C; for type E about 3C.

(4) The food must be eaten without cooking. Botulinal toxin is easily inactivated by boiling or even milder heat treatment.

Excluding any one of these conditions will eliminate the hazard of botulism.

Enterotoxins of *S. aureus* are responsible for the other major type of foodborne intoxication. Staphylococcal poisoning accounts for 20% to 40% of the foodborne illness outbreaks reported in the United States.[4,5]

The causal bacterium, *S. aureus,* is a common inhabitant of the skin, nose, and throat of humans. Certain strains of this species produce potent emetic toxin(s) that cause severe gastrointestinal distress. Symptoms include nausea, vomiting, retching, abdominal cramps, and diarrhea and are commonly expressed within one to six hours after the consumption of toxin-contaminated food.[6] Recovery is usually rapid, occurring in one to three days. The mortality rate is extremely low, but deaths have occurred in malnourished infants and in infirm adults.

Six serologically distinct staphylococcal enterotoxins have been identified. The most recently identified enterotoxin, type F, has been suggested as being a cause of the symptoms associated with toxic shock syndrome.[7] Like botulinal toxins, staphylococcal enterotoxins are proteins; however, their molecular weights are much smaller and their resistance to heat much greater than that of botulinal toxins. The potency of staphylococcal enterotoxins is only gradually decreased by prolonged boiling or autoclaving. Cooking foods will not inactivate these enterotoxins. The current best estimate of an emetic dose for man is less than 1 μg of staphyloccal enterotoxin.

Food handlers are the most common source of contamination of foods involved in staphylococcal food poisoning outbreaks. In the United States pork, particularly baked ham, is the food most frequently involved in outbreaks. Poultry, salads (meat, potato, etc) and cream-filled bakery goods are responsible for many of the remaining outbreaks. Toxin can form if susceptible food is contaminated (usually by a food handler) and held for several hours at a warm temperature.

Infection—Ingestion of infectious bacteria

A number of Gram-negative bacteria have been associated with food-related infections in humans. Examples include *Salmonella, Shigella, Campylobacter jejuni,* enteroinvasive *Escherichia coli, Vibrio parahaemolyticus, Yersinia enterocolitica* and *Brucella.* Food poisoning by these bacteria requires ingestion of living organisms, and in many instances ingestion of only a few active cells may be sufficient to initiate a gastrointestinal infection.

By far salmonellosis or *Salmonella* gastroenteritis is the most important foodborne disease. An estimated 2,000,000 Americans suffer from this disease each year, with at least half of the cases attributable to contaminated food.[8]

Salmonellosis is an intestinal infection caused by bacteria of the genus *Salmonella.* A wide spectrum of symptoms may be expressed but typically symptoms include nausea, diarrhea, abdominal cramps, and vomiting. The syndrome may be manifested by a few thin, vegetable-souplike stools, by a dysentery-like illness with bloody diarrhea and tenesmus, or by massive diarrhea with rapid dehydration and convulsions leading to death. Signs of illness usually appear within 12 to 24 hours after ingesting the organisms and persist for two to five days. The mortality rate is low but is not inconsequential, especially among the very young, the aged, and the infirm.

All salmonellae are presumed to be pathogenic for man, but of approximately 1800 known species only about 50 are associated with human infections in the United States. At one time it was believed that thousands or even millions of some strains of *Salmonella* had to be ingested to infect man; however, retrospective studies have revealed that ingestion of a few hundred viable cells or even less of certain species of *Salmonella* is needed to cause illness.

The major reservoir of salmonellae is animals which commonly harbor the organisms in their intestinal tracts. The majority of animals infected with *Salmonella* are symptomless carriers and foods obtained from these animals comprise the chief source of human infection. It is not uncommon

Table 1—Confirmed foodborne outbreaks and cases of microbial origin, 1976-1978.[a]

	1976	*1977*	*1978*
Bacterial			
C. botulinum	23 (40)	20 (75)	12 (58)
C. perfringens	6 (509)	6 (568)	9 (617)
Salmonella	28 (1,169)	41 (1,706)	45 (1,921)
Shigella	6 (273)	5 (67)	4 (159)
S. aureus	26 (930)	25 (905)	23 (1,318)
Others (7 agents)	3 (349)	4 (133)	12 (393)
Parasitic	9 (36)	15 (91)	7 (35)
Viral	3 (117)	4 (72)	5 (300)

[a]References [4,5]. Data represent the number of outbreaks with the number of cases in parentheses.

to find more than 25% of a particular lot of broiler chickens to be carrying salmonellae. Similarly turkeys and swine are often contaminated, as are cracked eggs.

Each year shigellae are responsible for a small but significant number of foodborne outbreaks reported in the United States. The disease produced by *Shigella* is known as bacillary dysentery or shigellosis which is characterized by symptoms of diarrhea, abdominal pain, fever, and vomiting. Stools often contain blood, pus, or mucus. The extent of the problem is poorly defined; however, incidents that have been reported are characterized by high attack rates, common-source epidemic patterns, and short incubation times (7 to 36 hours).

Shigellae are host-adapted to man and other primates. Most foodborne outbreaks result from a human carrier who has poor personal hygiene and touches a food that is not subsequently cooked. In the United States salads, particularly potato salad, prepared by food handlers are important vehicles of shigellae.

Campylobacter jejuni is an emerging foodborne pathogen that has recently been recognized as a major cause of acute bacterial gastroenteritis in humans.[9] Studies from throughout the world show that *Campylobacter* is as frequently isolated from patients with diarrhea as is *Salmonella.* Raw milk, processed turkey meat, cake icings, and raw clams have all been implicated as vehicles for outbreaks of *Campylobacter* infection. *C. jejuni* is widely distributed in nature often being present as part of the normal intestinal flora of swine, cattle, poultry, sheep, goats, and several species of wild birds.

In 1971 enteroinvasive *E. coli* was responsible for a severe and widespread outbreak of gastroenteritis that was traced to imported French Camembert cheese. At least 387 persons from throughout the United States were affected. Symptoms expressed by infected individuals were similar to those of shigellosis, with dysentery being a primary feature.

Vibro parahaemolyticus lives in marine environments and is primarily associated with food poisoning derived from seafoods. It is the leading cause of foodborne disease in Japan and has been identified in several American outbreaks.

Yersinia enterocolitica was first identified as a foodborne pathogen in 1976 when over 220 school children from Oneida County, New York were stricken with an acute intestinal illness.[10] Several of the children were hospitalized and were diagnosed as having appendicitis. Their symptoms included acute abdominal pain, fever, and diarrhea. Before the cause of their ailments was properly diagnosed, 16 of the children had appendectomies. *Y. enterocolitica* was identified as the causative agent and the source of the organism was found to be chocolate milk. This organism is a unique foodborne pathogen in that it can grow at 4C.

Brucellosis (undulant fever) is caused by selected species of the genus *Brucella.* Most human cases in the United States are traced to infected cattle or swine and infection may occur from ingestion of unpasteurized dairy products contaminated with *Brucella.* Years ago foodborne infections of brucellosis were not uncommon; however, today, as a result of an intensive program to eradicate brucellae from cattle and the introduction of regulations requiring pasteurization of milk, only occasional food-associated cases of brucellosis are reported.

Intoxication—Production of toxin in the gut

A third type of food poisoning requires ingestion of large numbers of living organisms that release enterotoxin(s) in the intestinal tract. Four such organisms include *Clostridium perfringens, Bacillus cereus, Vibrio cholerae,* and enterotoxigenic *E. coli.*

In the United States *C. perfringens* is the third leading cause of reported cases of food poisoning. Spores of *C. perfringens* are widespread in nature and are commonly associated with the intestinal tract of man and other animals. This organism is best known as the cause of gas gangrene, but certain strains elicit a mild gastrointestinal illness characterized by severe diarrhea and lower abdominal cramp pain, usually without vomiting. Onset is normally eight to 24 hours after consuming the contaminated food with complete recovery within 12 to 24 hours. The mortality rate is very low; however, fatalities occur occasionally among debilitated persons.

Usually implicated as causative factors in outbreaks due to *C. perfringens* are large amounts of cooked food, particularly meat, poultry, and gravies, that are subjected to a prolonged period of cooling (often overnight) and unrefrigerated storage. Millions of organisms per gram must be ingested to cause illness. Symptoms develop when large numbers of vegetative cells undergo sporulation in the intestinal tract, concomitantly releasing an enterotoxic component in the gut.

Much more of a problem in Europe than in the United States, *Bacillus cereus* is responsible for two different types of food poisoning. Symptoms of one type, the diarrheal syndrome, include abdominal pain, profuse watery diarrhea, rectal tenesmus, and moderate nausea, seldom giving rise to vomiting. Onset time is normally eight to 16 hours and symptoms usually do not last more than 12 hours. A variety of foods including cooked meat and poultry, cooked vegetables, and various dessert dishes have been implicated as vehicles for such outbreaks.

The symptoms and onset time of the second type, the vomiting syndrome, closely resemble those for staphylococcal food poisoning. Nausea and vomiting, but seldom diarrhea, occur between one and five hours after consuming several million organisms per gram of food. The vomiting-type incidents have primarily been reported in the United Kingdom and, with few exceptions, have been associated with

consumption of fried rice. The two different syndromes are believed to be caused by two distinct types of enterotoxin; *ie,* a diarrheal toxin and an emetic toxin.

In recent times very little consideration has been given to the foodborne disease significance of *V. cholerae* in the United States primarily because before 1978 the last reported outbreak of cholera to occur in this country happened in New York in 1911. However, in 1978, eight individuals from Louisiana were reported to have developed symptomatic illnesses due to *V. cholerae* after eating improperly cooked crabs.[11] Subsequent investigations found *V. cholerae* on fresh shrimp and in estuarine waters sampled from the Gulf Coast. Another outbreak was reported in Florida in 1979. In this instance several individuals developed cholera after eating raw oysters. Symptoms of cholera include sudden onset of vomiting, "rice-water" diarrhea, intense thirst, cold clammy skin, and dehydration resulting from the elaboration of a toxin, choleragen, by viable cells of *V. cholerae* in the gut.

Enterotoxigenic *E. coli* (ETEC) is presently thought to be the most common cause of "traveller's diarrhea" or "turista." A number of food-related outbreaks attributed to ETEC have occurred aboard cruise ships. Large numbers of the organism colonize the lower portion of the ileum and elaborate one or two toxins, singly or in combination. Symptoms of the illness are like those of cholera but milder. A serious need in studying the foodborne disease potential of *E. coli* is a rapid, reliable means of identifying those strains with disease potential.

Concluding Remarks

Food-related illnesses of bacterial origin account for a significant number of infections within the American population. The physician has a very important role in facilitating control of foodborne illness, namely, that of promptly reporting an illness thought to be foodborne to the public health authorities. Such reporting will enable an investigation of the outbreak in hope of learning the cause(s) so that future problems can be prevented.

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Schools benefit from nutrition education

AN INNOVATIVE federal program has provided nutrition education expertise to Wisconsin schools for the last three years. Teachers and school food service personnel together are given assistance in developing curriculums and corresponding activities using the latest nutrition education methods. This aid is provided by six nutrition education consultants working throughout the state.

The consultants are part of the Nutrition Education and Training (NET) Program, funded by the US Department of Agriculture and administered through the Wisconsin Department of Public Instruction. Nutrition education consultants work out of offices in Minocqua, Chippewa Falls, Green Bay, Sparta, Madison, and Milwaukee.

Although the major thrust of the program for long-term impact has been integration of nutrition concepts into the basic school curriculum, many interesting special projects also have been done. The "Nutrition Magician" has entertained first through sixth graders with magic tricks which teach the importance of a good breakfast and wise snack choices while they entertain. School food service directors have been given step-by-step assistance in obtaining parent and student involvement in their lunch programs.

Coaches and physical education teachers have attended sports nutrition workshops to learn how to better advise young athletes on their food intake. Weight loss among wrestlers has been a topic of special concern. Parents of pre-kindergarten children have been given healthful snack ideas while waiting for their child to be screened for school.

Unfortunately, just as the NET program was making headway in the schools, federal funding was drastically reduced. The six nutrition education consultants will work only through December 1981. Schools which have been participating in the NET program will have many new nutrition resource materials as a result of the program, but they will no longer have a qualified human resource readily available to them.

For additional information about the NET program, contact Carol Philipps, Acting NET Coordinator, Food and Nutrition Services, Department of Public Instruction, 125 South Webster, Box 7841, Madison, Wisconsin 53707.

THE STATE MEDICAL SOCIETY OF WISCONSIN

Created by the Territorial Legislature in 1841. . .representing nearly 5,000 member physicians in Wisconsin, comprising 55 county medical societies and 23 medical specialty sections. The purpose of the Society is to "bring together the physicians of the State of Wisconsin to advance the science and art of medicine and the better health of the people of Wisconsin, and to secure the enactment and enforcement of just medical laws." The major activities of the Society include continuing medical education, peer review, legislation, community health education, scientific affairs, socioeconomics, health planning, services for physicians, operation of a Charitable, Educational and Scientific Foundation, and publication of the *Wisconsin Medical Journal.*

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DHSS says it will honor T-19 contract with MDs

"The Department of Health and Social Services is prepared to honor the Society's interpretation of the current (Medical Assistance) provider contract based on Medicare profiles," the head of the State Division of Health (DOH) informed the Society Board of Directors Saturday, September 26. In a letter to the Society and SMS Physicians Alliance Chairman Kenneth M Viste Jr, MD, Oshkosh, DOH Administrator Kenneth Rentmeester agreed to adjust physician reimbursement under the WMAP program by 7.5% over 1980 levels. The DOH had previously informed the Society that it would limit physician reimbursement under the Medical Assistance Program to 4.5% during the coming year. SMS maintained that such action would be in violation of the current provider contract which requires the state to comply with the 1981-82 economic index adjustment applied by the federal government to Medicare which is 7.5%.

In other action at its September 26 meeting the Board:

•Supported a bill drafted at the request of the SMS Medical Liability Committee which would modify the composition of the WHCLIP Board of Governors to increase the number of physician representatives from 1 to 3.

•Opposed proposals of the Patients Compensation Panel's office to utilize resident and retired physicians as panel members. The Board recommended that retired physicians who practice less than 240 hours per year be allowed, but not obligated, to serve on a panel.

•Supported two proposals of the Patients Compensation Panel office that would: (1) limit the terms served by physicians so that a physician's obligation is fulfilled after having attended three panel hearings, and (2) credit physicians with panel service if a hearing is rescheduled within seven days of the hearing date.

•Supported AB 555 and SB 412, which would create a ten-member Radioactive Waste Review Board to negotiate with the Federal Department of Energy on matters relating to long-term disposal of radioactive waste.

•Heard a report on the Reagan administration's Block Grant approach to funding and its implications to Wisconsin health and medicine.

•Approved a recommendation of the *Wisconsin Medical Journal* Editorial Board to continue sending copies of WMJ to senior medical students in Wisconsin throughout their senior year.

•Reviewed proposed changes in the Joint Commission on Accreditation of Hospitals' Standards and directed staff to communicate the Board's concern with standards which would: (1) allow oral surgeons to admit patients to hospitals, and (2) require podiatrists to obtain the concurrence of a physician member of the medical staff prior to admission or discharge of a patient. In regard to the latter, the Board would like the language changed to "approval of a physician member of the medical staff."

•Received a progress report on a subcommittee of the Health Policy Council which is developing ways to encourage ambulatory surgery in Wisconsin.

•Approved a Statement from the SMS Committee on Alcoholism and Other Drug Abuse outlining "Guideline Admission Criteria for Chemical Dependency Treatment Services." (To be printed in an upcoming issue of MEDIGRAM and subsequently in the next BLUE BOOK issue of WMJ.)

continued next page

IF YOU WISH TO HELP AN IMPAIRED PHYSICIAN

The State Medical Society of Wisconsin's Impaired Physician Program wishes to identify, intervene, and bring about the rehabilitation of physicians impaired by use of alcohol and other drugs, or mental or physical infirmity. Persons may call 608/257-6781 or toll-free: 800/362-9080 and explain their concern to Mr John LaBissoniere or Mr H B Maroney of the Impaired Physician program staff. The caller's identity will be kept in complete confidence. ■

It's medical license renewal time again

Do you remember 1979? That was the year of the Medical Assistance Super Rule, the Iranian Hostages and 1,000 Wisconsin-licensed physicians failing to report 30 hours of continuing medical education (CME) credit to the Medical Examining Board.

The deadline for 1982-83 license renewal is rapidly approaching. By December 31 Wisconsin-licensed physicians must sign a statement on the application for registration to the Board certifying that s/he has completed 30 hours of acceptable CME. The Medical Examining Board will then conduct random audits to check the number and appropriateness of CME credits. This differs from the 1980-81 registration in that physicians will not have to submit *proof* that they have complied with the requirement.

It should be emphasized that this rule change *does not* eliminate the 30-credit rule. It merely discontinues the mandatory reporting procedure. It is the State Medical Society's understanding that if through an audit (or any other investigation), it becomes apparent that a physician has not received the proper number of acceptable credits, his/her license will be declared invalid. Ramifications of such an action could include: loss of medical staff membership, loss of medical malpractice insurance, and prosecution for practicing medicine without a license.

SMS strongly recommends that physicians maintain personal records of CME certification to avoid complications in the event of an audit. ■

ORGANIZATIONAL continued

•Went on record as supporting the University of Wisconsin-Madison School of Nursing program to prepare nurse practitioners at the master's level.

•Voted to provide a total of $25,000 in support to the Medical Museum at Prairie du Chien during 1981-83.

•Heard a report from SMS Services, Inc, that it was now "in the black" and that it has been successful in increasing the Avis Rent-a-Car discount to SMS members to 40%.

•Approved the following appointments to SMS Commissions and Committees: Steven Rosebrock, MD, Appleton, to the Committee on Environmental and Occupational Health; William J Maurer, MD, Marshfield, to the Commission on Governmental Affairs; Richard J Hendricks, MD, Madison, and Phillip M Green, MD, Marshfield, to the Committee on Aging and Extended Care Facilities; Gregory Von Roenn, MD, Milwaukee, to the Physicians Alliance Commission; and Hansi R Patience, MD, Sturgeon Bay, to the Committee on Women Physicians.

•Voted to submit the following names to DHSS to serve on an advisory Committee to the Department regarding Reimbursement: Jordon Frank, MD, Beloit (chairman-designate); Charles L Steidinger, MD, Platteville; Russell F Lewis, MD, Marshfield; Walter J Woloschek, MD, Milwaukee; Dean D Miller, MD, Milwaukee; Antoine Barrette, MD, Peshtigo; Curtis R Weatherhogg, MD, Madison; Mark Lochner, MD, Waupaca; John O Simenstad, MD, Osceola; Cornelius A Natoli, MD, LaCrosse; Richard H Patterson, MD, Milwaukee; William R Richards, MD, Appleton; Paul S Haskins, MD, River Falls; and John C Oujiri, MD, Ashland.

CES FOUNDATION

CONTRIBUTIONS—AUGUST 1981

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for August 1981.

Unrestricted

SMS Members—*Voluntary Contributions*

Restricted

NMC Projects, Inc—*General Scholarship Fund*
Donald R Beaver—*Aesculapian Society Membership Dues*
Leland Pomainville, MD—*LC Pomainville, MD, Fund*
Wisconsin Rural Rehabilitation Corporation—*Medical Student Summer Externship Program*

Memorials

Dr-Mrs Stephen D Austin—*Robert Petijean (Brown County Loan Fund)*
Dr-Mrs LaVern Herman—*Joseph Lubitz, MD (Joseph Lubitz, MD Fund)*
Gerald C Kempthorne, MD—*Paul Bourdeau; Mrs Betty Lou Spiegelhalter* ■

•Approved the following statement as official position of SMS re Antitrust:

"The State Medical Society of Wisconsin, in an effort to provide a climate of freedom of choice for both physicians and patients, will not, in its deliberations and actions:

"1. Adopt policies which knowingly restrict competition among physicians nor unduly hinder the ability of any member or group of members to compete.

"2. Enforce the Society's ethical principles in an arbitrary manner nor impose unreasonable sanctions for such violation(s).

"3. Require members to refrain from dealing with a member who has been disciplined for violating the principles of medical ethics." ■

IN MEMORIAM...

Parks Reinhardt, an SMS staff member for 19 years, died September 4, 1981 in Madison, Wisconsin. A person with a great sensitivity for others, she affected the lives of hundreds of Wisconsin citizens during her years with SMS. Parks began her service to the Society as Assistant Editor of the *Wisconsin Medical Journal* and later became Administrative Director for the Society's Charitable, Educational and Scientific Foundation (CESF). In recent years she served as Coordinator for the SMS-AMA Jail Health Care Project. Memorials in Parks' name may be made to the Charitable, Educational and Scientific Foundation. We will all sorely miss her. ■

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CME accreditation site surveyors needed

The Society's Commission on Continuing Medical Education, through its Subcommittee on Accreditation, is seeking additional surveyors for site visits to accredit hospital, specialty society, and county society continuing medical education programs.

According to Commission chairman, Leonard H Wurman, MD, Wausau, there are no special qualifications or limitations for physicians who wish to serve; there is no age barrier, and all specialties and any degree of involvement are acceptable. Physicians may serve as little as once a year or as many times as they wish. Physicians unfamiliar with the site surveys will accompany experienced surveyors three or four times before being asked to write a report, Doctor Wurman noted.

Since 1974 the Society's accreditation program surveyors have reviewed 120 hospital, 57 specialty society, and 4 county medical society CME programs. Currently the State Medical Society and the American Medical Association have accredited 51 hospitals and 27 specialty societies, and 1 county medical society.

If any member is interested in participating in site survey visits, contact SMS offices in Madison: Arlene Meyer or Bill Wendle at 608/257-6781 or toll-free 1-800-362-9080. ■

A 'thank you' to CME site surveyors

The SMS Commission on Continuing Medical Education wishes to thank its Subcommittee on Accreditation and the 69 surveyors who have completed at least one site survey during the period December 1974 to September 1, 1981. Nine of the surveyors have completed 10 or more surveys.

Surveyors are listed below in alphabetical order, with those having done 10 or more surveys noted with an asterisk and those who are members of the Subcommittee on Accreditation noted with (SOA).

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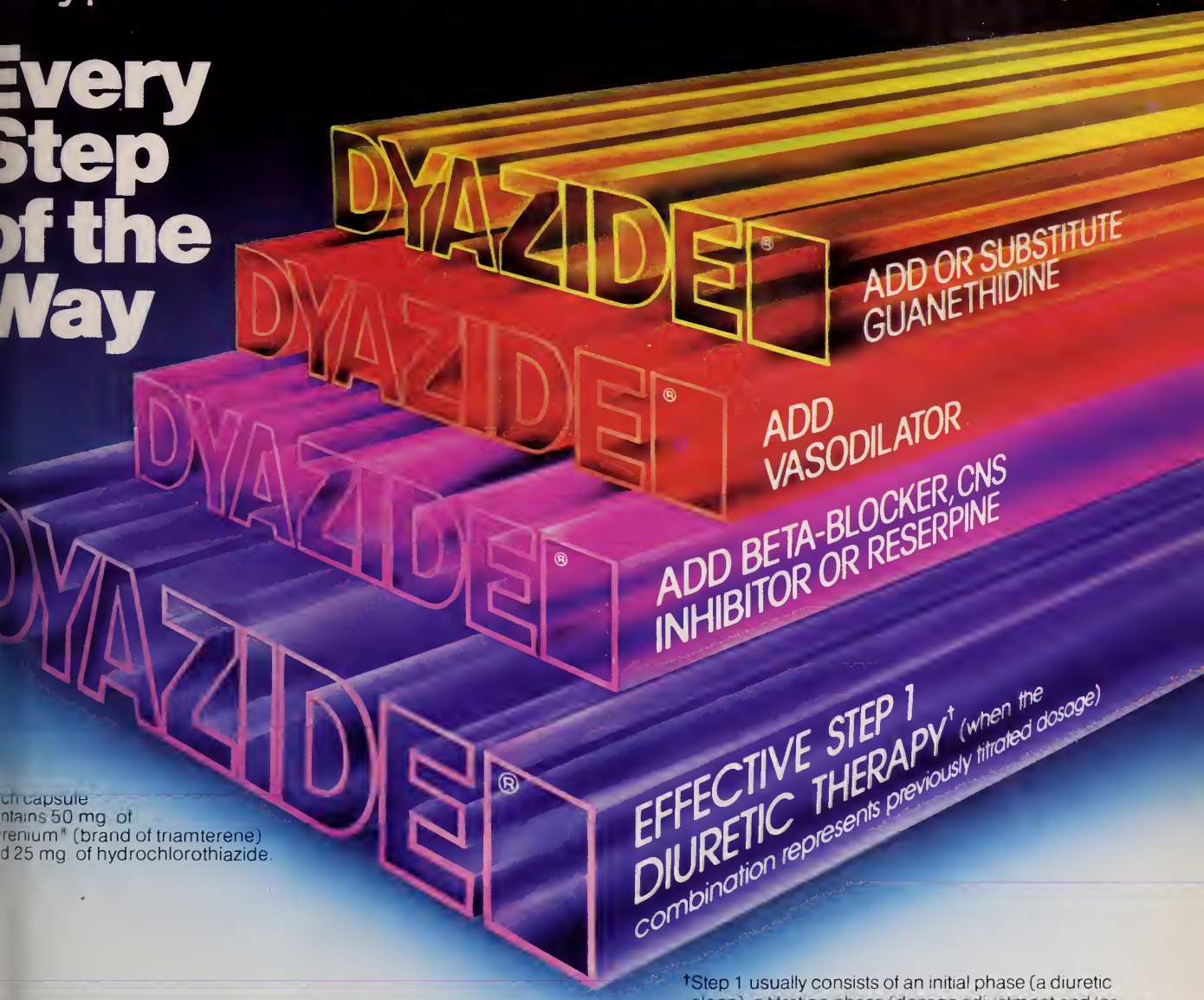

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traindications: Further use in anuria, progressive renal epatic dysfunction, hyperkalemia. Pre-existing elevated m potassium. Hypersensitivity to either component or sulfonamide-derived drugs.

nings: Do not use potassium supplements, dietary or rwise, unless hypokalemia develops or dietary intake otassium is markedly impaired. If supplementary potas- is needed, potassium tablets should not be used. Hyper- mia can occur, and has been associated with cardiac ularities. It is more likely in the severely ill, with urine me less than one liter/day, the elderly and diabetics with ected or confirmed renal insufficiency. Periodically, m K^+ levels should be determined. If hyperkalemia lops, substitute a thiazide alone, restrict K^+ intake. **Asso- d widened QRS complex or arrhythmia requires mpt additional therapy.** Thiazides cross the placental ier and appear in cord blood. Use in pregnancy ires weighing anticipated benefits against possible haz- including fetal or neonatal jaundice, thrombocytopenia, adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently, both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide' although a causal relationship has not been established.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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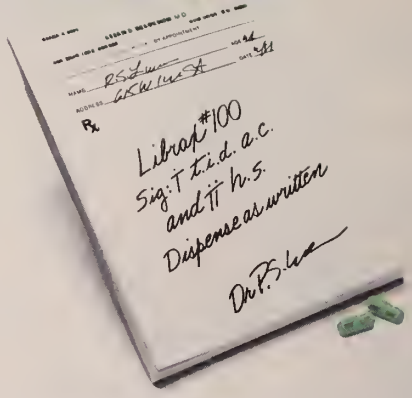

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.

"Possibly" effective as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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rtist's concept of myoelectrical slow waves f the colon which seem to determine the equency of colonic motor activity.

A visible difference in myoelectric rhythms of the colon

Studies reveal an increased frequency of 3-cycles-per-minute slow wave basic electrical activity in the colons of patients with IBS—a significant difference in basic colonic rhythm patterns from normal subjects.[1,2] These findings suggest a physiological basis for the spasm and hypermotility characteristic of IBS. The role of severe anxiety in triggering or aggravating such symptoms has long been recognized. Consequently, treatment should focus on both aspects of the problem.

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References: 1. Sullivan MA, Cohen S, Snape WJ: *N Engl J Med 298:*878-883, Apr 20, 1978. **2.** Snape WJ *et al: Gastroenterology 72:* 383-387, Mar 1977.

Specify **Librax®** Adjunctive

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/Antispasmodic

*Librax has been evaluated as possibly effective for this indication. Please see summary of prescribing information on facing page.

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getting there...

...takes dietary restriction, regular exercise, behavior modification, and sometimes the addition of an effective anorectic.

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(diethylpropion hydrochloride USP)

75 mg controlled-release tablets

the #1 prescribed anorectic

An effective short-term adjunct in an indicated weight loss program

Overweight patients in certain diagnostic categories often require strict obesity control. Diethylpropion hydrochloride has been reported useful in obese patients with certain complications. While it is not suggested that Tenuate in any way reduces these complications in the overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. Tenuate should not be administered to patients with severe hypertension; see additional Precautions and Adverse Reactions on this page.

In uncomplicated obesity

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 18 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate–it makes sense. And it's responsible medicine.

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References: 1. Citations available on request from Merrell Dow Pharmaceuticals Inc., Cincinnati, Ohio 45215. 2. Hoekenga M T et al: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed, New York. Raven Press, 1978, pp. 391-404.

Tenuate* ⓒIV
(diethylpropion hydrochloride USP)

Tenuate Dospan* ⓒIV
(diethylpropion hydrochloride USP)
controlled-release
AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personalty changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release. One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

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Governmental Affairs acts on chiropractic proposal

A proposal which would require hospitals to provide outpatient services to chiropractic patients upon referral of a chiropractor was opposed by the SMS Governmental Affairs Commission in September. The author of the bill draft, The Wisconsin Chiropractic Association, has added five "exceptions" in an effort to reduce opposition to the proposal:

(1) Hospitals would not be obligated to offer "new" services to meet the needs of chiropractic referrals.
(2) Hospitals could not establish charge differentials between physician- or chiropractor-referred patients.
(3) The hospital would not be required to grant staff privileges to referring chiropractors.
(4) Hospitals could refuse referrals if the refusal is based upon "professional cause."
(5) The bill exempts hospitals from liability of the acts of referring chiropractors.

The Commission said that allowing chiropractors to make outpatient referrals would result in chiropractors interpreting medical evaluations—something chiropractors are not trained to do. Medical evaluations and diagnostic tools would be used to justify chiropractic treatment modes, the Commission said.

In other action September 9, the Commission took positions on the following legislative proposals:

Look-alike drugs—SB 536: Prohibits the fraudulent advertising of drugs, and regulates the commercial trafficking of substances that resemble controlled substances. *Supported.*

Prescription of hypodermic syringes—AB 564: Places hypodermic syringes in the same status as prescription drugs under the pharmacy laws. The Commission *opposed* the bill on the grounds that it would place a hardship on patients when they travelled outside the state and that syringe prescription would not solve the illicit drug problem.

Psychologists as expert witnesses—AB 607: Expands the scope of authorized professionals who may examine a defendant in establishing probable cause and in testifying concerning mental condition. Upon the recommendation of the SMS Committee on Mental Health, the Commission overturned its August 12 position and *opposed* the bill on the grounds that a physician should always be involved in the examination of a patient.

Abortion and aids program—AB 621: Prohibits abortions in publicly owned hospitals and facilities except under limited circumstances. The bill also established an aids program for children born after the bill's effective date who have Tay-Sachs disease, spina bifida, anencephaly, Down's syndrome, or hydrocephalus. The Commission *opposed* the bill due to the substantial fiscal note of the aids program.

Marijuana decriminalization—AB 693: Decreased the penalties for the simple possession or gift of marijuana or its derivatives. *Opposed.*

Therapeutic use of marijuana—AB 697: Creates a Controlled Substances Therapeutic Research Program to provide marijuana, or its derivatives, for medical purposes to patients suffering from glaucoma or the side effects of cancer therapy. *Opposed.*

Temporary licensure of physicians—AB 710: Allows the Department of Regulation and Licensing to determine whether a physician will be granted a temporary license to practice medicine in Wisconsin. Currently, two members of the Medical Examining Board make the determination upon recommendation from staff. *Opposed.*

Dogs for research—SB 536: Requires humane societies and dog pounds to release unclaimed dogs to medical institutions when requested for research purposes. *Supported.* ■

SMS testifies in support of Panels bill

"Service on Patients Compensation Panels is the obligation of every Wisconsin physician," William Treacy, MD, Milwaukee, told members of the Assembly Judiciary Committee last month.

Doctor Treacy, along with Walter Moritz, MD, Fort Atkinson, and Russell Quirk, MD, Racine, (all members of the SMS Medical Liability Committee), represented the State Medical Society on a legislative ad hoc committee which reviewed problems confronted by the Panel director, physicians, and attorneys, and developed Assembly Bill 537 in response to these problems.

Included in this legislation are provisions to:

1. Define more clearly the length of terms to be served by physician Panel members so that terms are not drawn out indefinitely.
2. Establish a greater number of formal Panels throughout the state so that no individual Panel is overburdened.
3. Limit the amount of awards available to claimants who originally request less than $25,000, increasing the reimbursement to physician and attorney Panel members from $75 to $150 per meeting.

continued on next page

4. Empower the Medical Examining Board to warn or reprimand a physician, limit, suspend, or revoke a physician's license as a sanction for refusal to serve on a Panel without good cause.

Doctor Treacy told the committee that these provisions will result in more efficient and effective resolution of medical liability disputes, and urged the committee to take favorable action on the bill. ■

Hospital code revision underway

A special committee has been meeting over the past few months to revise the State's Administrative Code for hospitals (H-24) which was first promulgated in 1968.

The Committee consists of representatives from SMS, the Wisconsin Hospital Association, two nursing service directors, a director of medical records, and hospital surveyors from the State's Bureau of Quality Compliance. SMS President Albert J Motzel Jr, MD, Waukesha, is the Society's representative on the committee.

The revisions will focus on technical revisions to the Code such as deleting or modifying outdated regulations and reorganizing various sections to make them more understandable.

To date the committee has revised portions of Sections on Medical Records and Medical Staff, the Section on Compliance with Federal, State and Local Laws, and Governing Body—General Management. Still to be considered are the sections dealing with employee health and infection control, nursing service, and physician environment. Further details of the H-24 Code revision will appear in future issues of *WMJ*. ■

SMS calls for keeping current licensing board system

"If decades of legislative intent with respect to professional boards—that is, citizens bringing expertise to a licensing bureaucracy still is valid, then these recommendations fail miserably in reflecting that intent," SMS Physicians Alliance Director Brian Jensen said recently in written remarks to the Joint Committee on Audit.

Jensen was referring to a Legislative Audit Bureau report on the Department of Regulation and Licensing which calls for transferring the authority for complaint and investigation, examination and rule-making functions from the various state licensing and occupational boards to the Department.

"In the final analysis," Jensen said, "these recommendations will cripple beyond repair the effective licensing boards, including the Medical Examining Board. He urged the committee and Legislature to preserve the current licensing board system for health professionals since the audit report failed to identify any shortcomings of these boards."

"The Legislature should instead determine which boards are ineffective and unnecessary and deal with them accordingly," he said. ■

Health Division head to emphasize public health role

"The Division of Health has slipped away from its leadership role in public health" the new administrator of the Wisconsin Division of Health, Kenneth Rentmeester, told members of the State Health Policy Council in late August. Rentmeester said it is time to restore confidence in public health, expand activities and concerns about environmental health, and to move more health program responsibilities to the local level where the consumer can "lever the decision makers."

In his first official appearance before the State Health Policy Council, he expressed wide-ranging views on many health issues, including concern about the lack of flexibility in proposed block grants from the federal to state government, the need for more business people to become involved in health planning, and steps to control the use of pesticides in central Wisconsin.

Rentmeester said that he was particularly startled in taking over his new responsibilities to learn that Medicaid has grown in two years from a $500 million program to a near $900 million program in Wisconsin. He said the "average use of physicians' services by Medicaid recipients is two times that of middle and upper income persons who obtain private MD services."

He said it was ironic that we may need to reassess the notion that everyone should be assured high quality and easily accessible care as expressed in health planning activities over the past several years. He suggested that the state and the public may now have to look at some of the economic issues associated with this goal and that "technology may have outdistanced our ability to pay for it."

Rentmeester sees the need to "move back to a more cooperative relationship between government and providers rather than continuing the state's very strong regulatory role." He said, "we can't afford to continue to fight each other." ■

Have you served on a Panel?

William Bissett, Director of the Patients Compensation Panels, has contacted SMS regarding the frequent refusal of physicians to serve on the Panels. It should be noted that state law requires physicians to serve on Panels unless excused by the Panel director.

The expertise of Panel members is the feature of the Panel system which sets it apart from the courts and ensures that allegations of medical malpractice will be reviewed by knowledgeable individuals. The continued refusal of physicians to participate in this service jeopardizes the Panel system itself and has the potential of placing medical liability actions back into the jury trial setting.

The SMS Medical Liability Committee wishes to remind all Wisconsin physicians of their obligation to serve on the Patients Compensation Panels and advises physicians that upon passage of AB 537, instances of refusal to serve without good cause will be referred to the Medical Examining Board for investigation. ■

Physician Briefs

*Physician members of State Medical Society of Wisconsin

Terrence L Meece, MD, Ashland, recently joined the medical staff of Memorial Medical Center in Ashland. Doctor Meece graduated from the University of Illinois, Abraham Lincoln in Chicago and completed his family practice residency at Midland Hospital Center, Midland, Mich. Prior to moving to Ashland, Doctor Meece served as the associate director of the Midland Family Practice Residency Program and as assistant Clinical Professor in the Department of Family Practice, College of Medicine, Michigan State University.

Frank S Guzowski, MD, Marshfield, recently became a member of the Department of Internal Medicine at the Marshfield Clinic. Doctor Guzowski graduated from the Michigan State University College of Human Medicine, Lansing, Mich. He completed his internship and residency at the Mayo Clinic, Rochester, Minn.

Gary H Shaw, MD, Marshfield, recently became associated with the Marshfield Clinic in the Department of Internal Medicine specializing in nephrology. He graduated from the Michigan State University College of Human Medicine in Lansing and completed his training at the Mayo Clinic, Rochester, Minn.

Richard P Reigel, MD, Stevens Point, recently became a member of the medical staff of the Rice Clinic in Stevens Point. He is associated with Philip K Hacker, MD,* in the Department of Urology. Doctor Reigel graduated from the University of Wisconsin Medical School, Madison, and completed a rotating internship at York Hospital, York, Pa. He served in the United States Navy for three years. Doctor Reigel completed his residency at the Medical College of Wisconsin, Milwaukee, and had been in private practice in Lafayette, Ind, prior to joining the Clinic.

Robert J Brumblay, MD, LaCrosse, recently became associated with the Gundersen Clinic, Ltd. Doctor Brumblay graduated from the University of Wisconsin Medical School, Madison, and served his internship and residency at E W Sparrow Hospital, Lansing, Mich, and at Michigan State University, respectively. He is at the Lutheran Hospital Emergency Medical and Trauma Center.

Maurice Bakaleinik, MD,* Minong, recently began his medical practice with the Northwoods Medical Cooperative Clinic. He graduated from the University of Brussels Medical School and served his residency at Jewish Memorial and Unity hospitals in New York. Further training in surgery was completed at Fordham and Metropolitan hospitals also in New York. He was on the medical staff at Veterans Administration hospitals in Fargo and Minot, ND for ten years, and was in private practice for 13 years in New York. Prior to joining the Clinic in Minong, he had been in private practice in Milwaukee. He is a fellow of the American College of Surgeons.

Ben R Lawton, MD,* Marshfield, recently was appointed to the Institute of Medicine Board on Health Care Services. His term will extend through February 1983. The board, with headquarters at the National Academy of Sciences in Washington, DC, is one of three Institute of Medicine panels being established under a cooperative agreement between the Institute and the Department of Health and Human Services to address health problems. Doctor Lawton has been a member of the Marshfield Clinic medical staff since 1954 and served as the Clinic's president for eight years. He is a recent recipient of the University of Wisconsin's Max Fox Preceptor Award.

Willard G Huibregtse, MD,* Sheboygan, recently retired from the medical staff of the Sheboygan Clinic. He joined the medical staff in 1934 after graduating from the University of Wisconsin Medical School. Doctor Huibregtse served in the United States Army Medical Corps from 1943 to 1945 and also served a two-month period with the Volunteer Physicians for Vietnam in 1969. He served as president of the medical staff at St Nicholas Hospital in 1960 and at Sheboygan Memorial Hospital in 1968. In 1962 he served as president of the Sheboygan County Medical Society and as its secretary-treasurer from 1936 through 1943.

S Craighead Alexander, MD,* Madison, chairman of the Department of Anesthesiology at the University of Wisconsin Medical School, Madison, recently was elected president of the Society of Academic Anesthesia Chairmen and the Society of Neuroanesthesia and Neurologic Supportive Care.

Doctor Lawton

Doctor Huibregtse

Doctor Alexander

Allon H Bostwick, MD, Shawano, recently became associated with the medical staff of the Cantwell-Peterson Clinic. He graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency at the Waukesha hospitals.

Howard Gollup, MD, Wauwatosa, recently became associated with the Harwood Medical Associates in Wauwatosa. Doctor Gollup graduated from the University of Wisconsin Medical School, Madison, and completed his residency in pediatrics at the University of Nebraska Medical Center in Omaha.

Stephen P Delahunt, MD, Oconomowoc, has joined the medical staff of the Wilkinson Clinic in Oconomowoc. Doctor Delahunt graduated from the Medical College of Wisconsin, Milwaukee, and served an internship at St Joseph Hospital in Denver, Colo, where he also practiced family medicine. In 1977 he returned to the Medical College of Wisconsin to complete his residency training in orthopaedic surgery. He also completed a fellowship in hand surgery in Edinburgh, Scotland.

Ante Grgic, MD,* Rhinelander, specialist in pediatrics, pediatric endocrinology, genetics and metabolism with Northwood Medical Associates, recently was cited for his scientific contribution to a better understanding of diabetes mellitus in the July 23, 1981 issue of *The New England Journal of Medicine.* Doctor Grgic graduated from the medical school at the University of Zagreb in Yugoslavia and completed his internship and training at the same school. He came to the United States in 1971 and completed more training at the University of Maryland. He also earned a fellowship in pediatrics, endocrinology, genetics and metabolism from the University of Florida in Gainesville in 1972. He has been associated with the Northwoods Medical Associates since 1976.

John E Kippenhan, MD,* Cedarburg, recently left his medical practice of 24 years to become associated with an Urgent Care Clinic in San Jose, Calif. Doctor Kippenhan graduated from the University of Wisconsin Medical School, served in the United States Army Medical Corps, and had been part-time city health officer since April 1967.

Peter M Ries, MD,* Marshfield, recently became associated with the Marshfield Clinic. He graduated from the University of Wisconsin Medical School in Madison and served his internship and residency at the Marshfield Clinic, St Joseph's Hospital, Marshfield.

Rama P Mukherjee, MD, Marshfield, has become a member of the medical staff of the Marshfield Clinic. A native of India, Doctor Mukherjee graduated from Calcutta Medical School. He completed his surgical residency training in England and Scotland and was a staff physician in New Delhi, India. In the United States he completed further training at the University of Chicago, Christ Hospital in Cincinnati, and at New York University Hospitals.

Leland J From, MD, Beloit, recently became associated with the medical staff of the Beloit Clinic. Doctor From graduated from the Chicago Medical School and completed his residency training in internal medicine with the Mayo Clinic in Rochester, Minn.

D King Aymond, MD, Sheboygan, recently became associated with the Sheboygan Clinic. Doctor Aymond served in the United States Navy for two years, and then entered the University of Texas Medical School graduating in 1975. His internship and residency, in ophthalmology, were completed in the Galveston Hospital in Texas.

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*Data on file Parke-Davis Marketing Research Dept.
**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*, IMS America Ltd., September 1980.

PD-400-JA-0146-P-1 (1-81)

TUCKS® Pre-Moistened Hemorrhoidal/Vaginal Pads
Hemorrhoids and other anorectal uses–TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witchhazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.
Vaginal Uses–Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate
ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
1089G010

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Richard B Stafford, MD,* Neenah, former clinical director of Winnebago Mental Health Institute, recently became associated with the Outagamie County Community Board as its clinical director. Doctor Stafford is in charge of program planning, clinical services, and supervision of the direct service staff. He joined the Winnebago medical staff in 1964 after completing his psychiatric residency at the University of Wisconsin Hospital and Clinics in Madison. Doctor Stafford had been working for the Community Board as a consultant since 1975.

Norman Frost, MD, Madison, recently was elected a fellow in the American Academy of Pediatrics. Doctor Frost is an associate professor of pediatrics and history of medicine at the University of Wisconsin, Madison, and a member of the medical staff at Madison General and University of Wisconsin hospitals.

Robert W Mackie Jr, MD, recently became associated with the medical staff of the Wausau Medical Center. He graduated from Cornell University Medical College, New York City, and served his internship and residency at Dartmouth Medical Center, Hanover, NH, and Latter Day Saints Hospital, Salt Lake City, Utah. Doctor Mackie also completed a fellowship in cardiology at the University of Utah and was the recipient of a National Science Foundation Research Award.

Richard D Hutter, MD, LaCrosse, has become associated with the Gundersen Clinic, Ltd. He graduated from the University of Minnesota Medical School and served his internal medicine residency at the Mayo Clinic in Rochester. Doctor Hutter completed his neurology training at the University of New Mexico School of Medicine, Albuquerque.

Bruce A Wallin, MD, LaCrosse, recently became a member of the medical staff of the Gundersen Clinic, Ltd. Doctor Wallin graduated from the University of Minnesota Medical School and completed his residency training at West Virginia University Medical Center in Morgantown.

William H Squires, MD, Janesville, has become a member of the medical staff of the Janesville Riverview Clinic. He graduated from the Medical College of Wisconsin, Milwaukee, and served his residency at Milwaukee County General Hospital.

Bruce Melin, MD, recently became a member of the medical staff of the Lakeview Medical Center in the Department of Pathology in Rice Lake. A 1977 graduate from the University of Wisconsin Medical School, Madison, Doctor Melin completed his residency at Northwestern Memorial Hospital in Chicago.

Robert Moss, MD, Cross Plains, recently opened his family medicine practice at the Cross Plains Clinic. A native of Chicago, Doctor Moss graduated from the University of Illinois School of Medicine, Chicago, and completed his residency at Lutheran General Hospital in Park Ridge, Ill.

Thomas Snowden, MD, Ashland, recently became associated with MDs Howard N Sandin* and Edward M Vernier.* Doctor Snowden graduated from the University of Illinois Medical School and completed his residency training at Ohio State University and the University of Virginia. He served in the United States Air Force for three years and was chief of pediatrics at the Altus Air Force Base hospital in Okla.

Edward J Hoy, MD, Watertown, has joined the medical staff of Watertown Memorial Hospital in the Department of Ophthalmology. Doctor Hoy graduated from the St Louis University School of Medicine and served his internship at St John's Mercy Hospital in St Louis. He completed his residency at St Louis University.

John A Kozisek, MD, Stevens Point, recently became associated with C A Klasinski, MD* in the medical practice of orthopedic surgery. Doctor Kozisek graduated from the St Louis University School of Medicine and served an internship at Rockford Medical Foundation, University of Illinois. His residency was completed at Henry Ford Hospital, Detroit, Mich. He is a diplomate of the National Board of Medical Examiners.

Richard P Boyer, MD, Stevens Point, recently became associated with the medical staff of the Rice Clinic. Doctor Boyer graduated from Tufts University School of Medicine, Boston, and completed a rotating internship at Hartford Hospital in Conn. His residency was taken at Boston and Akron City hospitals. He practiced medicine in LaCrosse and Janesville from 1976 to 1979, when he entered Rutgers Medical School's Middlesex General Hospital, New Brunswick, NJ to complete a fellowship in vascular surgery.

Lawrence Carlson, MD, has become a member of the medical staff of the Indianhead Medical Group. Certified by the American Board of Family Practice, Doctor Carlson graduated from the University of Minnesota School of Medicine and completed his residency at North Memorial Hospital in Minneapolis. He recently completed a tour of duty with the United States Army Medical Corps stationed at Heidelberg, West Germany.

Robert A Albani, MD, Wausau, has become a member of the medical staff of the Wausau Medical Center. He graduated from Loyola University Medical School, Chicago, and served his internship at the University of Missouri Medical Center. Doctor Albani also completed his residency training in anesthesiology at the University of Missouri Medical Center. ■

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PD-400-JA-0146-P-1 (1-81)

Medical College of Wisconsin, Milwaukee, has announced the appointment of Bettie Sue Siler Masters, PhD, as professor and chairman of the Department of Biochemistry at the College. Doctor Masters graduated from Roanoke College, Salem, Va, in 1959, and was awarded a United States Public Health Service predoctoral fellowship at Duke University where she was a research associate. Upon completion of her doctoral degree in 1963 in biochemistry, she received a two-year postdoctoral fellowship from the American Cancer Society. She served an additional two years at Duke as advanced research fellow of the American Heart Association. In 1968 she joined the University of Texas as assistant professor of biochemistry and received the American Heart Association's five-year Established Investigator Award. Doctor Masters also had served as professor of biochemistry and research professor of surgery and director of biochemical burn research at the University of Texas Health Science Center at Dallas, Southwestern Medical School. She is the first woman chairman in the school's history. Nationally, less than two percent of department chairmen in medical schools are women, the Medical College notes. Her appointment is effective June 1982.

Bettie Masters

St Mary's Hospital Medical Center, Green Bay, recently announced that Allison C Laabs, Executive Vice President, recently became a member of the American College of Hospital Administrators (ACHA). A native of Green Bay, Mr Laabs has been chief executive officer of St Mary's since 1975. Prior to coming to St Mary's, he was assistant administrator for St Anthony's Hospital, Effingham, Ill. He received a Master's degree in Philosophy from Catholic University of America, Washington, DC, and earned a Master's degree in Hospital Administration from Cornell University in Ithaca, New York. ■

"WATS" LINE FOR MEMBERS

As a service for its members, the State Medical Society of Wisconsin has a **toll-free** WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

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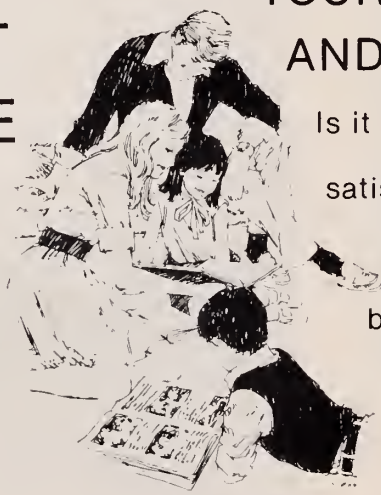

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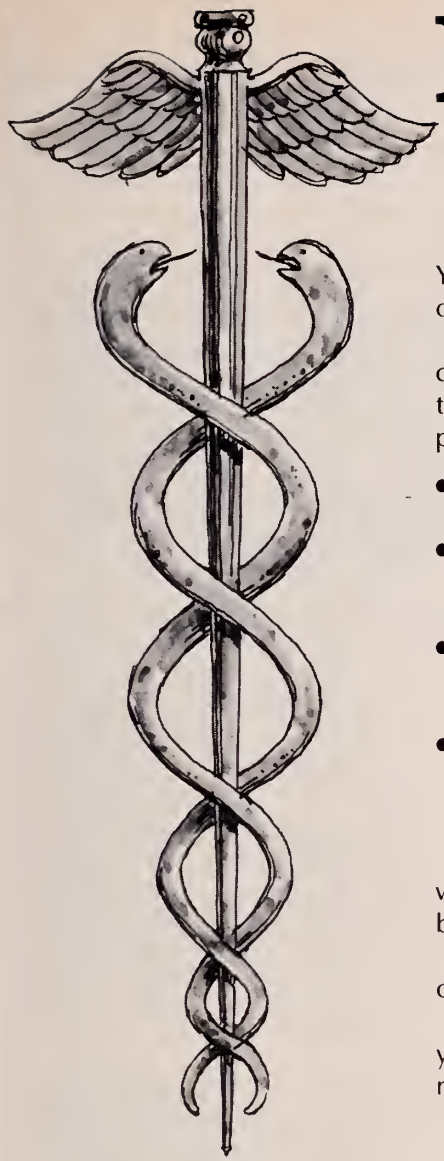

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First Wisconsin National Bank of Fond du Lac
55 South Main Street
Fond du Lac 54935
(414) 922-3200

GREEN BAY—Jeffrey L. Johnson
First Wisconsin Bank of Green Bay
425 Pine Street
Green Bay 54305
(414) 432-0321

MADISON — James E. Sugar
First Wisconsin National Bank of Madison
First Wisconsin Plaza
Madison 53707
(608) 252-4157

MILWAUKEE — Jeffrey S. Syslack
First Wisconsin Trust Company
777 East Wisconsin Avenue
Milwaukee 53202
(414) 765-5071

OSHKOSH — Wilson K. Roane
First Wisconsin National Bank of Oshkosh
111 North Main Street
Oshkosh 54903
(414) 424-4276

RHINELANDER — Robert A. Schultz
First Wisconsin Trust Company (Trust Services Office)
First National Bank of Rhinelander
8 West Davenport Street
Rhinelander 54501
(715) 362-6900

WAUSAU — Robert A. Schultz
First Wisconsin National Bank of Wausau
400 Scott Street
Wausau 54401
(715) 845-1125

WISCONSIN RAPIDS — Philip L. Dunmire
First Wisconsin Trust Company (Trust Services Office)
First National Bank of Wisconsin Rapids
311 West Grand Avenue
Wisconsin Rapids 54494
(715) 424-1788

FIRST WISCONSIN

FWT-39

Obituaries

Elmer E Debus, MD, 79, Wisconsin Rapids, died May 26, 1981 in Wisconsin Rapids. Born Jan 28, 1902 in Chicago, Ill, Doctor Debus graduated from the University of Wisconsin Medical School and served his internship at the Robert B Greene Memorial Hospital in San Antonio, Tex. He had practiced at the Jackson Clinic, Madison until 1943 and moved to Wisconsin Rapids where he had his medical practice until his retirement in 1977. He was a licensed examiner for the Federal Aviation Agency and a licensed pilot. Surviving is his daughter, Mary of Middleton.

John W Prentice, MD, 84, Washburn, prominent Ashland area physician, died Aug 5, 1981 in Ashland. Born Mar 7, 1897 in Ashland, Doctor Prentice graduated from the University of Minnesota Medical School in 1922 and served his internship at Minneapolis General Hospital. His residency was completed at Eitel Hospital in Minneapolis. Doctor Prentice practiced medicine in the Ashland area from 1929-1965. He was a member of the House of Delegates of the State Medical Society of Wisconsin and also was a member of the Committee on Grievances of the Society. He was appointed to the State Board of Medical Examiners in 1947 and served as its president from 1953-1955. He was president of the Wisconsin Society of Obstetrics and Gynecology and also was a member of the American College of Obstetricians and Gynecologists. In 1972 he became a member of the "50 Year Club" of the State Medical Society of Wisconsin. Doctor Prentice was a member of the Ashland-Bayfield-Iron County Medical Society and the American Medical Association. Surviving are his widow, Margaret; two daughters, Sally Bannister, Leesburg, Florida, and Beverly Walker of Clearwater, Georgia. His son, Bruce Culver Prentice, MD died July 8, 1981.

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Thomas H Rees, MD, 87, Manitowoc, died Aug 9, 1981 in Manitowoc. Born Nov 5, 1893 in Niles, Ohio, Doctor Rees graduated from Western Reserve University Medical School in Cleveland and served his internship and residency at City Hospital, Cleveland, Ohio. Doctor Rees served on the medical staff of Memorial and Holy Family hospitals. He was a past president of the Manitowoc County Child Guidance Center and Manitowoc Heart Campaign Fund. In 1972 he received an award of merit from Memorial Hospital Corporation, and in 1976 he received a "Distinguished Service Award" from the Manitowoc Lions Club. Surviving are two sons.

Robert L Demke, MD, 56, Westfield, died Aug 15, 1981 in Wautoma. Born May 12, 1925 in Chicago, Illinois, Doctor Demke graduated from Loyola University Medical School in Chicago, and served an internship at the United States Marine Hospital, Chicago. He had practiced in Westfield and Wautoma since 1960. He had served as president, secretary, and delegate to the State Medical Society from Green Lake-Waushara County Medical Society. He also had served as chief of staff at the Wautoma Memorial Community Hospital. Doctor Demke also was a member of the American Medical Association. Surviving are his widow, Frances, Westfield; five sons, Dr Robert, Barrington, Ill; Dr Richard, Princeton; Dr Donald, Freeport, Ill; Dr Thomas, Stevens Point; William, Westfield; and a daughter, Georgia of Westfield.

Louis Brachman, MD, 80, former Milwaukee ophthalmologist, died Aug 25, 1981 in Hallandale, Fla. Born Sept 25, 1901 in Latvia, he graduated from the Marquette University School of Medicine, Milwaukee, and served his internship and residency training at the University of Chicago. He was an associate professor emeritus at the old Marquette Medical College and for many years directed the eye clinic at Marquette before retiring 10 years ago. Surviving are his widow, Rose and a son, James of Great Neck, NY. ■

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Membership Directory UPDATE

Prepared from the August 17, 1981 Membership Report and from member notifications to Wisconsin Medical Journal for updating the 1980-81 Membership Directory published in the January 1981 issue.

Physicians are reminded that the newly revised Constitution and Bylaws, as adopted by the 1981 House of Delegates and printed in the June 1981 *Blue Book* issue, state that "any member whose current year's dues have not been received by the secretary of this Society by May 15 shall be deemed in arrears and his name shall be removed from the membership rolls of his county society and this Society until such time as full dues for the current year have been received." Reelected members are those physicians who previously were members. Reinstated members are those physicians removed from membership who have been returned to the roster without a break in membership. Physicians removed from membership include those who resigned, moved out of state, or failed to pay current dues.

ASHLAND-BAYFIELD-IRON

Deceased members

Prentice, Bruce C—July 8, 1981

CHIPPEWA

New members

TS GS
Winskunas, Philip F
127 West Central
Chippewa Falls 54729

Reelected members

GS
Cook, Steven D
2501 County Trunk 1
Chippewa Falls 54729

Address changes

New	*Old*
GS **Gonzaga, Fe Q** PO Box 22 Chippewa Falls 54729	347 Prairie View Rd

County society transfers

GP
Hanley, Larry L
347 Prairie View Rd
Chippewa Falls 54729

from: Eau Claire-Dunn-Pepin

DANE

Reinstated members

1M GE
Vander Meer, James E
1313 Fish Hatchery Rd
Madison 53715

Address changes

New	*Old*
FP **Bernardoni, Robert J** 516 Wells St Darlington 53530	6497 Whalen Rd Verona 53593
IM **Blume, Peter** RFD 1 Box 287 Concord NH 03301	5240 Harbor Court Madison 53705
AN **Boncyk, John C** 5404 Mathews Rd, #221 Middleton 53562	831 Bradley Ave Eau Claire 54701

DANE continued

IM **Doezema, David** 1204 6th St Las Vegas NM 87701	4114 Mandan Crescent Madison 53711
IM **Evans, Joseph J** 6122 Hazelwood Ave Indianapolis IN 46208	5510 Meadowood Dr Madison 53711
AN **Hellman, Daniel R** 7405 N Braeburn Lane Milwaukee 53209	5305 Manitowoc Parkway Madison 53705
IM **Hutter, Adolph M** 34 Golf Course Rd Madison 53704	PO Box 8340 Madison 53708
ORS GS **Kruse, Diana L** 4134 Twin Valley RD Rte #6 Middleton 53562	6745 Schroeder Rd Apt 7 Madison 53711
1M **Lempert, Kenneth D** 733 Augusta Ave Morgantown WV 26505	4833 Sheboygan Ave Madison 53705
PTH **Schwartz, Sheldon M** 79 Parkwood St Williamsport PA 17701	1729 Norman Way Madison 53705
PTH **Wester, Susan M** 1836 South Ave LaCrosse 54601	1230 Madison St LaCrosse 54601
GS **Zonnebelt, Steven M** 155 West 27th St Holland MI 49423	600 Highland Ave Madison 53792

DOUGLAS

New members

ORS GS
Muenzner, Paul S
3500 Tower Ave
Superior 54880

Address changes

New	*Old*
1M **Reibold, Robert J** 3600 Tower Ave Superior 54880	7 Royalton Rd

EAU CLAIRE-DUNN-PEPIN

Address changes

New	*Old*
GS	
Haumschild, Ronald L	
810 Kimberly St	1030 Oakridge Dr
Eau Claire 54701	

County society transfers

Hanley, Larry L — to: Chippewa

GRANT

New members

FP
Railey, Robert M
235 N Madison St
Lancaster 53813

Reelected members

FP
Ruf, David F
641 Clay St
Darlington 53530

Reinstated members

GS GP
Lagman, Raul M
Route 2
Cuba City 53807

KENOSHA

Address changes

New	*Old*
IM	
Ali, M Yusuf	
3200 Sheridan Rd	3618 8th Ave, #9
Kenosha 53140	
R	
Huberty, Lee H	
8747 1st Ave	6929 2nd Ave
Kenosha 53140	

Reinstated

IM
Zeihen, Michael
1015 65th St
Kenosha 53140

LACROSSE

Reinstated members

IM CD
Goren, Carolyn C
1836 South Ave
LaCrosse 54601

Removed from membership

Kalfayan, Bernard

MANITOWOC

Address changes

New	*Old*
OPH	
Jiroch, John T	
3330 Atlanta Rd, #H-5	2809A S Superior St
Smyrna GA 30080	Milwaukee 53207

Deceased members

Strong, Russell G—June 23, 1981

MARATHON

Address changes

New	*Old*
FP	
Burwitz, James E	
604 W Milwaukee St	801 Gilbert St
Mauston 53948	Wausau 54401

MARATHON continued

OTO	
Flannery, John V Jr	
20 North Hill Rd	1215 Spring St
Wausau 54401	
AN	
Oh, Shenton M	
10009 43rd Place NE	1018 Crocker St
Seattle WA 98125	Wausau 54401
GP	
Peterson, Thomas H	
995 Schofield Ave	801 Gilbert St
Wausau 54401	

MARINETTE-FLORENCE

Deceased members

Boren, Clarence H—July 12, 1981

MILWAUKEE

Address changes

New	*Old*
FP	
Beaver, Donald R (DO)	
6901 W Edgerton Ave	
PO Box 20928	500 N 19th St
Milwaukee 53220	Milwaukee 53233
GP OM	
Bernhart, Ervin L	
13475 Commons Dr	3216 Menomonee River
Brookfield 53005	Milwaukee 53222
IM	
Conradson, Eric P	
2222 N Mayfair Rd	425 E Wisconsin Ave
Wauwatosa 53226	Milwaukee 53202
PN	
Dagon, Eugene M	
5851 N Shore Dr	9191 Watertown Plank Rd
Whitefish Bay 53217	Milwaukee 53226
GS PS	
Das, Dilip K	
3224-B S 27th St	2040 W Wisconsin Ave
Milwaukee 53215	Milwaukee 53233
Ethington, James E	
2923 W Layton Ave	2388 N Lake Dr
Greenfield 53217	Milwaukee 53211
GS	
Haugh Jr, John J	
811 E Wisconsin Ave	2243 N Prospect Ave
Milwaukee 53202	
IM	
Holbrook, Arthur A	
3050 E Newport Court	2518 East Lake Bluff
Milwaukee 53211	
IM	
Johnson, Gordon L	
6630 Hill Ridge Dr	8700 W Wisconsin Ave
Greendale 53129	Milwaukee 53226
GS	
Jurishica, August J	
9425 W Hadley St	2500 N 108th St
Milwaukee 53222	Milwaukee 53226

MILWAUKEE continued

P CHP
Kalogjera, Ikar J
1220 Dewey Ave
Milwaukee 53213

9501 Watertown Plank Rd
Milwaukee 53226

PH
Krumbiegel, Edward R
3410 Gulf Shore Blvd N
Naples FL 33940

612 S Bayshore Dr
Elk Rapids MI 49629

ORS
Kulkarni, Vijay V
2315 N Lake Dr, #706
Milwaukee 53211

2388 North Lake Dr

IM CD
Lipoff, Jay I
214 East Spooner Rd
Milwaukee 53217

4100 W Cherrywood Lane
Brown Deer 53209

R
Marks, Jerome L
2870 Luciernaga St
Carlsbad CA 92008

2607 Pirineos Way

IM
Paz, Eduardo
3569 S Howell Ave
Milwaukee 53207

7205 Dorchester Lane
Greendale 53129

OBG
Perlson, Samuel G
788 N Jefferson St, #301
Milwaukee 53202

425 E Wisconsin Ave

AN
Phillips, Wilson S
2200 West Skyline Rd
Milwaukee 53209

6167 N Berkeley Blvd
Milwaukee 53217

OBG
Riendl, Anne M
2907 Farmview Court
Waukesha 53186

2171 N 40th St
Milwaukee 53208

IM
Royce Jr, Owen J
2222 N Mayfair Rd
Wauwatosa 53226

425 E Wisconsin Ave
Milwaukee 53202

D
Russell, Thomas J
3000 W Brown Deer Rd
Milwaukee 53209

881 East Spooner Rd
Milwaukee 53217

OBG
Sable, Morris H
788 N Jefferson St, #301
Milwaukee 53202

425 E Wisconsin Ave

GS
Sullivan, John T
2300 N Mayfair Rd, #890
Wauwatosa 53226

2040 W Wisconsin Ave
Milwaukee 53233

OBG
Wagner, Alan M
788 N Jefferson St, #301
Milwaukee 53202

425 E Wisconsin Ave

MILWAUKEE continued

Reinstated members

OBG
Bodner, Aaron C
700 N Water St
Milwaukee 53202

OBG
Castillo, Marcelo G
1672 S 9th St
Milwaukee 53204

FP
Eichenberger, Charles R
1425 E Capitol Dr
Milwaukee 53211

EM
Hargarten, Stephen W
PO Box 503
Milwaukee 53201

R GS
Kim, Yong W
14850 Westover Rd
Elm Grove 53122

P
Larson, Craig
811 E Wisconsin Ave
Milwaukee 53202

FP
Lubsey, Vincent G
2711 West Wells St
Milwaukee 53208

GS CDS
Mendiola, Rolando M
8860 Greenview Lane
Greendale 53129

R
Milbrath, John R
11339 Underwood Court
Wauwatosa 53226

CD IM
Puchner, Thomas C
2300 N Mayfair Rd
Milwaukee 53226

Deceased members

Pugh, George J—May 1, 1981

OUTAGAMIE

Reinstated members

GP
Mielke, John E
900 E Grant St
Appleton 54911

OZAUKEE

Address changes

New	*Old*
GP **Kippenhan, John E** 475 N Green Bay Rd Grafton 53024	W62 N536 Washington Ave Cedarburg 53012

PORTAGE

Reinstated members

OBG
Bergin, Steven C
2501 Main St
Stevens Point 54481

RACINE

Address changes

New	*Old*
GE IM **Geenen, Joseph E** 1333 College Ave Racine 53403	407 13th St

ROCK

Address changes

New	*Old*
ORS **Baldwin, Raymond M** 2563 Riverside Dr Beloit 53511	1920 West Hart Rd

ROCK continued

D
Levin, Harlan M
408 S River St — One S Main St
Janesville 53545

SHEBOYGAN

Address changes

New — *Old*

PTH
Dick, Herman J
5666 East Hampton — 629 Torrey Pl
Tucson AZ 85712 — Goleta, CA 93117

VERNON

Address changes

New — *Old*

GP GS
Boston, Thomas E
516 Brayton St
Dyersburg TN 38024

WALWORTH

Address changes

New — *Old*

GS ON
Seldera, Juanilito N
Route 1, Box 259A — (addition)
Fontana 53125

WAUKESHA

New members

FP
Lindemann, Janet C
434 Madison St
Waukesha 53186

Address changes

New — *Old*

OBG
Burch, Kim R
PO Box 427 — W180 N7950 Townhall Rd
Menomonee Falls 53051

OBG
Chumbley II, Clyde M
PO Box 427 — W180 N7950 Townhall Rd
Menomonee Falls 53051

IM ID
Dailey, Michael P
PO Box 427 — W180 N7950 Townhall Rd
Menomonee Falls 53051

FP
Gage, Robert B
14 Shefford Circle — 434 Madison St
Madison 53719 — Waukesha 53186

GS TS
Russo, Mark H Gia
PO Box 427 — W180 N7950 Townhall Rd
Menomonee Falls 53051

IM PUD
Herrell, Daniel W
PO Box 427 — W180 N7950 Townhall Rd
Menomonee Falls 53051

WAUKESHA continued

OPH AN
Hovey, John C
PO Box 427 — W180 N7950 Townhall Rd
Menomonee Falls 53051

IM
Iverson, Gary O
PO Box 427 — W180 N7950 Townhall Rd
Menomonee Falls 53051

R
Madden, Peter N
12778 W North Ave — 19333 W North Ave
Brookfield 53005

D
Marek, Robert W
PO Box 427 — W180 N7950 Townhall Rd
Menomonee Falls 53051

ORS
McWhirter, Robert E
PO Box 427 — W180 N7950 Townhall Rd
Menomonee Falls 53051

R
Pearce, Jan D
12778 W North Ave — 17030 W North Ave
Brookfield 53005

GP
Reichle, Robert I
W228 N683 Westmound Rd — PO Box 427
Waukesha 53186 — Menomonee Falls 53051

R
Ruggaber, Garren C
16780 Dane Court West — W180 N7950 Townhall Rd
Brookfield 53005

PTH
Rykwalder, Paul J
2360 Kevenauer Dr — 15000 W North Ave
Brookfield 53005

PTH CLP
Schambert, Jay F
PO Box 408 — W180 N8085 Townhall Rd
Menomonee Falls 53051

Reinstated members

EM
Helz, Timothy J
4774 N Pinecrest Dr
Nashotah 53058

U
Herrmann, Richard A
17030 W North Ave
Brookfield 53005

WINNEBAGO

Address changes

IM
Basiliere, James L
414 Doctors Court — 515 Doctors Court
Oshkosh 54901

WINNEBAGO continued

IM
Weber, William G
414 Doctors Court
Oshkosh 54901

515 Doctors Court

Reinstated members

OBG
Bartizal Jr, Frederick J
1416 S Commercial St
Neenah 54956

WOOD

New members

END IM
Coombs, Guerdon J
1000 North Oak Ave
Marshfield 54449

GS
Harris, Frederick L
515 Marathon St
Marshfield 54449

Address changes

New *Old*

IM
Niehaus, Rebecca Conway
203 Schiek Plaza Dr
Rhinelander 54501

524 North Apple St
Marshfield 54449

GS
Speltz, Stephen M
1304 Troy St
Wausau 54401

808 South Oak Ave
Marshfield 54449■

"WATS" LINE FOR MEMBERS

As a service for its members, the State Medical Society of Wisconsin has a **toll-free** WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

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AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored by organizations accredited for these activities. The State Medical Society of Wisconsin congratulates the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

JULY 1981

Barad, Richard M, Madison
Beltran, Luciano R, Menomonee Falls
*Bogunovic, D P, Milwaukee
Buegel, Dale M, Shorewood
Clarke, Gerald P, Oshkosh
*Darrow, Gregory L, Janesville
*Davidoff, Donna D, Brown Deer
*Davis, Donald P, Milwaukee
Di Clementi, David, Wauwatosa
Fenster, Diane L, Green Bay
*Fiedler, Howard W, Milwaukee
*Gordon, Michael C, Janesville
*Hancock, Curtis W, Sheboygan
Hoeft, Irwin P, Oconomowoc
*Horvath, Edward P, Marshfield
Hoy, Edward J, Watertown
*Huebner, Timothy K, Wisconsin Rapids
Humphrey, John A, Shorewood
*Janssen, Gary J, Greenwood
*Janssen, William C, Thiensville
*Kane, Alex M, Milwaukee
*Keepman, Jay P, Madison
Kienker, Karen A, Madison
Knier, Michael S, Oshkosh
*Kuzdas, James R, West Allis
Lareau, Thomas G, Edgar
*Lichty, James E, Milwaukee
Litscher, Lawrence J, Burlington
*Loescher, Thomas M, Appleton
Loynd, James W, Madison
Mac Rae, Scott M, Madison
*Majeski, Henry E, Luxemburg
*Mannis, Kent S, Madison
*McAuliffe, Edward P, Sturgeon Bay
Mitchell, Danl M, Florence
*Nash, Richard G, Ladysmith
Nowak, Blaine B, Janesville
*Pelton, Russell S, Ripon
*Petersik, John T, Oshkosh
*Phillips, Robert E, Marshfield
*Pruett, William A, Beloit
Rizzo, Michael J, Milwaukee
Schultz, Duane A, McFarland
Sendele, Robert L, Wauwatosa
Stenger, George S, Brookfield
*Sullivan, Bradley J, Marshfield
*Swenson, Franklin H, Chippewa Falls
*Taman, Mahmoud S, Chippewa Falls
*Thompson, Lester A, Rice Lake
Troy, James L, Wauwatosa
*Vangor, Donald W, Baraboo
Vanik, Richard K, Wauwatosa
Verhulst, Larry J, New Berlin
*Viel, Ruby S, Brookfield
*Vitacca, Rocco J, Janesville
*Wallace, Charles C, Appleton
Weston, Robert L, Oshkosh
*Yerex, Joyce A, Racine
*Zurek, Wladyslaw A, Marshfield

Members of the State Medical Society of Wisconsin

AUGUST 1981

Cesarec, Robert G, Milwaukee
*Chattertown, Howard T, Ladysmith
*Hanley, Larry L, Chippewa Falls
*Hansen, Raymond A, Milwaukee
*Hitselberger, James F, Fond du Lac
*Holder, Richard L, Black River Falls
MacCarthy, John P, DePere
*McNeal, Wesley E, Green Bay
*Paloucek, James T, Milwaukee
*Vanderspek, Hans G, Marshfield ■

County Societies

*Physician members of State Medical Society of Wisconsin

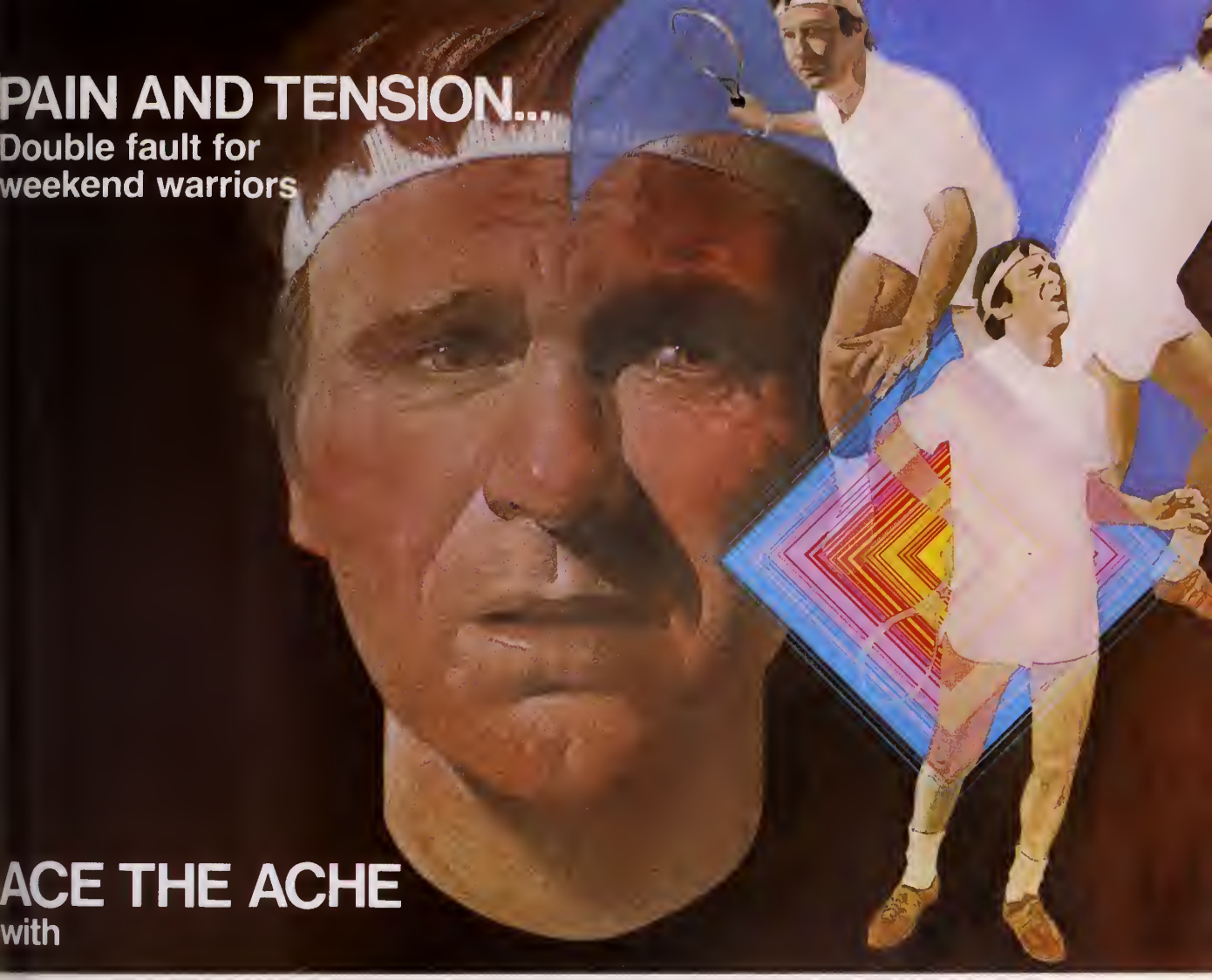
MILWAUKEE: The Medical Society of Milwaukee County's Impaired Physicians' program will be highlighted in a future feature article in the *Ladies Home Journal.* MSMC President, Doctor Charles Landis, and Committee Chairman, Doctor Martin Denio, described the Society's program and impairment in general in late August for the article's authors.

WINNEBAGO: Forty members and four guests were present at the Winnebago County Medical Society September meeting to hear Folkert Belzer, MD, Chief of Surgery at University Hospitals, Madison. Doctor Belzer presented a paper on "Surgical Treatment of Renal Vascular Hypertension." Thirteen physicians have applied for membership in the Society and it was announced that George W Arndt, MD, had been nominated for a position on the Medical Examining Board by Governor Lee Dreyfus. ■

See also *Membership Directory—Update* section for list of new members and membership changes by county medical society.

Medical history speaker available

Need a speaker for an upcoming county medical society meeting? Leland C Pomainville, MD, Wisconsin Rapids, will present half-hour programs on the history of medicine upon request. Doctor Pomainville, who is an authority on medical history and the State Medical Society's historian, will speak on several topics including: "Indian Medicine," "Sitting Bull and Medicine Man," "Peyote Ceremony," "The Wounded Presidents," "Civil War Medicine," and "Tetanus Convulsions During a Polio Epidemic"—showing how medicine has changed from early days to now. For more information contact Doctor Pomainville at 521 Eighth Street South, Wisconsin Rapids, WI 54494. ■



Equagesic®℠

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

Twofold analgesic action teamed with time-proven efficacy against concurrent anxiety and tension in patients with musculoskeletal disease.*

EQUAGESIC—Abbreviated Summary

*INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows
"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache
Final classification of the less-than-effective indications requires further investigation
The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgment and coordination.
USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.
Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.
Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.
Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and lightheadedness with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, PA 19101

for mild to moderate pain

Wygesic®IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill, however laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I.V., simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237 2406-2407 1977).
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Medical Yellow Pages

RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

Energetic Family Practitioner needed to join busy group practice consisting of four physicians. Central Wisconsin town of 15,000 with drawing area of 25,000. Excellent salary first year with many fringe benefits. Full partnership next year. Send CV to Merrill Medical Associates, SC, 716 E 2nd St, Merrill, Wis 54452. 9-11/81

Experienced Emergency Physician sought for four-man group, Southeastern Wisconsin. Annual visits 24,000. Modern facility with full specialty back-up. Equal sharing shifts. Fee for service. 90 K per annum. Emergency experience desirable. ACLS. Send CV or call R J Krill, MD, 3801 Spring St, Racine, Wis 53405; ph 414/636-4011. 9-10/81

Oncologist needed to join the only two oncologists in the community working within a multispecialty group of 22 physicians at the Racine Medical Clinic. The Clinic is a progressive organization offering a competitive salary for the first 18 months with a full ownership thereafter and a full fringe benefit package. Contact R D Lacock, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis; ph 414/886-5000. 10 tfn/81

General Surgeon. Board eligible/certified to join primary care group of six family physicians. Well established, rural setting, preceptor University of Wisconsin, JCAH 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis 54615. 10 tfn/81

Neurologist, Allergist, Cardiac Surgeon, Nephrologist, Psychiatrist. Opportunities in small group private practice. Tertiary referral center with active teaching program and fully equipped hospital including advanced lab facilities, CT scanner, oncology program, cath lab, cardiac surgery, neurosurgery, dialysis, etc. Service area 300,000 plus. Unspoiled university city on Lake Superior offers outstanding recreational opportunities. Contact: J D Wojcik, MD, Chairman, Recruitment Committee, Marquette General Hospital; ph 906/228-9449, ext 434. 10-21/81

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095
pl-12/81

Medical Ophthalmologist wanted to join established, growing practice in beautiful Lake Tahoe-Reno, Nevada area. Excellent climate and year-round recreational facilities. Will consider full or part-time or retired physician. Contact Karen Grodowitz, MS, Executive Director, Reno Eye Clinic, 1530 E 6th St, Reno, Nev 89512; ph 702/329-1389. 10 tfn/81

Family Practitioners to work in community clinics near Madison, Wisconsin. Combination of a community office practice with privileges at major Madison hospitals. Family practitioner will join an already established internist to continue the growth of a medical practice, expand a small pediatric practice, and begin an obstetrical practice. Clinics are full service and have professional personnel support. Physicians have a guaranteed compensation package and an option to purchase the clinic from the community. Please send resume to T Arnfelt, Madison General Hospital, 202 South Park St, Madison, Wis 53715. 10-11/81

Internist wanted to join a 14-physician multispecialty group in one of northern Wisconsin's finest recreation areas. Modern 109-bed hospital. Excellent professional and personal opportunity. Contact Dr J Wiesner, Lakeland Medical Associates Ltd, Box 549, Woodruff, Wis 54568 or call 715/356-3292. 5tfn/81

Internist wanted, with or without subspecialty, to join long established private practice in Southeastern Wisconsin community of 75,000. Superb hospital facilities, totaling 600 beds. Excellent schools, University, and College facilities. Easy access to Milwaukee and Chicago. Position available now. Call collect 414/654-4562. 8-11/81

Pediatrician to join 3-BC pediatricians in city of 50,000. Good hospital with specialties well represented. Good schools, recreation with many lakes, university. Address replies with CV to: John B Hughes, MD, Oshkosh Children's Clinic, 645 Doctors Court, Oshkosh, WI 54901. 8-10/81

Emergency Physicians. Full-time openings for ER physicians with group serving hospitals in Manitowoc, Sheboygan, Wisconsin Rapids, Shawano, Oconto Falls, and other cities. Excellent starting salaries, flexible schedules. Must be willing to relocate to area. Send CV to: Central States Emergency Physicians, PC, 1846 Hoffman St, Suite 101, Madison, Wis 53704 or ph 1/800-362-7366. 7-12/81

Surgeon with Thoracic general vascular training, Pediatrician, and Ophthalmologist to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

Physicians Exchange

continued

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties. *Family Practice, Hematology/Oncology, Neurology* and *Otolaryngology.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 7tfn/81

Racine Medical Clinic, multispecialty group of 22 physicians has a practice association for internist. The clinic is progressive and offers a rewarding professional career. Competitive salary for the first 18 months with full ownership after. Full fringe benefit package. Contact R D Lacock, Admin, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis 53406. Phone 414/886-5000. 5tfn/81

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Neurologist to join a three member neurology/neurosurgery group in Waukesha County. Negotiable salary with potential for full partnership after one year. Contact: James C Hanson, MD, Neurologic Associates of Waukesha Ltd, 1111 Delafield St, Waukesha, Wis 53186. p9-11/81

Physician wanted to perform light physicals on a full or part-time basis. Ideal job for retiring physician. Contact Mike Stough collect at 513/621-8728. 10 tfn/81

Family Physician wanted to establish new office in growing community in Southeastern Wisconsin. Local hospital will assist financially with income guarantee, relocation expenses and startup costs. Send CV to Professional Relations, UHS, 1 Presidential Blvd, Bala Cynwyd, Pa 19004. 10/81

ENT wanted to establish practice adjacent to hospital in growing Southeastern Wisconsin city. Modern office available. Income guarantee, startup costs and relocation expense reimbursement available. Send CV to Professional Relations, UHS, 1 Presidential Blvd, Bala Cynwyd, Pa 19004. 10/81

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive, Madison, Wisconsin 53716
Phone: (608) 222-2927 *Licensed Employment Agency*

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Family Practice, Internal Medicine and Pediatric positions available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303; ph 414/494-5611. 9-12/81

Attractive Emergency Room Opportunity. Lake Geneva area. Day shifts. Guaranteed minimum. Contact William Lange at Lakeland Hospital. Phone 414/723-2960. 9tfn/81

Orthopedic Surgeon to join an established two-man department in a multispecialty group located adjacent to an expanding medical center in Western Wisconsin. The community offers a wide variety of year-round cultural and recreational opportunities for the entire family. Our corporate organization offers a generous first-year guaranteed salary and production-incentive income thereafter. The fringe benefit package is all inclusive and most attractive. Contact Director of Professional Affairs, Skemp-Grandview-LaCrosse Clinic, Ltd, 815 S 10th St, LaCrosse, Wis 54601. 9-11/81

Two Family Practice Physicians sought to assume a fully operational practice in a community 30 miles north of Madison, Wisconsin. New clinic facility. Income guaranteed. Physician back-up available. Board certified or eligible preferred. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 5tfn/81

Family Practice. General Clinic—Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

How About An Offer You Can't Refuse? Sound interesting? Over 200 opportunities for MDs—all specialties, all situations. Just a quick call is all that's necessary for info on location and details. MEDICUS, W62 N281 Washington Ave, Cedarburg, Wisconsin 53012; ph 414/377-6550. 10/81

CompHealth—Locum Tenens. Physicians covering physicians, nationwide, all specialties. We provide cost-effective quality care. Call us day or night. T C Kolff, MD, President, CompHealth, 175 W 200 S, Salt Lake City, Utah 84101; ph 801/532-1200. p7-10/81

General Internists. Board Certified or Eligible, to join 40-physician multispecialty medical group located on Milwaukee's east side overlooking Lake Michigan. Adjacent to 300-bed hospital. Salary plus bonus and comprehensive fringe benefit package. Contact Eugene Daun, Administrator, Northpoint Medical Group, Ltd, 2388 North Lake Drive, Milwaukee, Wis 53211. 9-10/81

Emergency Medicine Opportunities. Directorship and clinical positions available in the greater Milwaukee area. Excellent income, paid malpractice insurance, and flexible scheduling provided. For details, send credentials in confidence to Michael Dixon, 970 Executive Parkway, St Louis, MO 63141; or call toll-free 1/800-325-3982. 5-10/81

Psychiatrist—medical director for a comprehensive community mental health center in beautiful Southwest Wisconsin. Staff of 70 with a 2.5 million dollar budget. Serving a population base of 70,000. Salary and fringe benefits negotiable. Contact: Paul Ranum, Program Director, Unified Board of Grant and Iowa Counties, 250 N Court St, Platteville, Wis 53818. 10tfn/79

Physician's Assistant seeks relocation. Have national-Wisconsin state certification. Experience in rural primary care and general surgery. Prefer small community or rural family practice in Southeastern Wisconsin. Resume and references upon request. Contact Dept 494 in care of the Journal. 9tfn/81

Fond du Lac—26 physician incorporated multispecialty group on the south shore of Lake Winnebago needs a fourth pediatrician. Guaranteed salary with full shareholder status available after one year. Send CV to Kirk A Veit, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 9tfn/81

Opportunities for General and Vascular Surgeon and Orthopedic Surgeon. SE Wisconsin location. Close to Milwaukee, Madison, and Chicago. Our facility is immediately adjacent to 126-bed hospital. Good salary structure with incentive program for first year. If you are interested in further information, please contact Administrator, Burlington Medical Center, 190 Gardner Ave, Burlington, Wis 53105. p9-10/81

Internist with training in pulmonary disease needed to join a 22-physician multispecialty group in Appleton, Wis. Excellent hospitals, guarantee plus incentive compensation. Complete benefit package. Medium size community. Contact Art Schuetze, Administrator, Medical Arts Clinic, SC, 401 N Oneida St, Appleton, Wis 54911. Phone 414/739-0171. 9-11/81

Family or General Practitioner wanted at small town clinic in NW Wisconsin within one hour of Duluth. Rural area offers fishing, boating, hunting, skiing. Fully equipped clinic and support staff provided. Salary plus benefits and/or net income split. Send resume to WH Erskine, NWMC, Box 86, Minong, WI 54859; or call 715/466-2201. 8tfn/81

General and vascular surgeon, FACS, Board certified, highly qualified, with several years of practice, would like to join an individual or group with an established practice in metropolitan Milwaukee area. Contact Dept 493 in care of the Journal. 7tfn/81

Obstetrician-Gynecologist, Board certified or eligible, to join 13-physician multispecialty group in metropolitan Milwaukee. Community of 31,000 offers excellent cultural, educational, and recreational facilities. Guaranteed first-year salary plus incentive. Ownership and comprehensive fringe benefit program available after one year. Send CV or inquiries to: PO Box 97, Butler, Wis 53007. 7tfn/81

Orthopedist—with interest in sports medicine, available in late 1982 upon completion of residency. Prefer moderate-sized college community. Contact Dept 495 in care of the Journal. p10/81

Medical Facilities

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

For Sale: Hamilton examining room table and matching cabinet. Like new. Phone: 414/453-6432, Milwaukee. 8tfn/81

Milwaukee Suburb Family Practice available near Elmbrook Hospital. Low time commitment, yet nets over 50k per year. Donald Wood, MD, 17400 North Ave, Brookfield, Wis 53122; ph 414/786-5400. 8-11/81

For Sale: Eau Claire, well equipped and maintained medical office. Near downtown, on bus line; eleven hundred square feet; waiting room, private office, four examining rooms, laboratory. Ground floor, parking in rear. Rented four room and bath apartment above. General practitioner retiring after thirty years. Large patient following. Selling building and equipment. General practitioners needed. Contact: George E Wahl, MD, 616 E Grand Ave, Eau Claire, Wis 54701; ph 715/835-8038. 10 tfn/81

EENT used equipment for sale. Telephone 608/233-6571. 9/81*

Real Estate

Vail Condo. Two-bedroom, kitchen, living room, fireplace, beautiful view. $570/week. Ralph N Bloch, MD, 9950 West 80th Ave, Arvada, Colo 80005; ph 303/425-0961 or 303/399-9076. p 10/81

Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

Health Services Directory: A Topical Guide to Clinics, Treatment Centers, Rehabilitation Facilities, Counseling/Diagnostic Services, and Care Programs. First Edition. Edited by Anthony T Kruzas. 1981. Gale Research Co, Detroit, Mich 48226. Pp 620. Price: $60.00.

Exercise in Health and Disease. Edited by Francis J Nagle, PhD and Henry J Montoye, PhD. Charles C Thomas, 301-327 East Lawrence Ave, Springfield, Ill 62717. 1981. Pp 326. Price: $31.75.

Current Surgical Diagnosis & Treatment. Edited by J Englebert Dunphy, MD and Lawrence W Way, MD. Lange Medical Publications, Los Altos, Calif 94022. Pp 1138. Price: $25.00.

Wisconsin Medicine, Historical Perspectives. Edited by Ronald L Numbers and Judith W Leavitt. University of Wisconsin Press, 114 N Murray St, Madison, Wis 53715. 1981. Pp 212.

Goodbye Blues: Breaking the Tranquilizer Habit the Natural Way. By Bernard Green, PhD. McGraw-Hill Book Co, 1221 Avenue of the Americas, New York, NY 10020. 1981. Pp 192. Price: $10.95.

A Textbook of Biological Feedback. By Mariella Fischer-Williams, MD; Alfred J Nigl, PhD; David L Sovine, MD. Human Sciences Press, 72 5th Ave, New York, NY 10011. 1981. Pp 511.

Caution "Kindness Can Be Dangerous to the Alcoholic." By Abraham J. Twerski, MD. Prentice-Hall, Inc, Englewood Cliffs, NJ 07632. 1981. Pp 174. ■

Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1981 through Aug 31, 1982.

WISCONSIN

OCTOBER 30-31, 1981: *Osteoporosis,* Madison. University of Wisconsin, Extension, Dept of Continuing Education; and University of Wisconsin, School of Medicine, Department of Preventive Medicine. AMA Category I; AOA and family practice credit pending. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison 53706; ph 608/263-2856.

NOVEMBER 9, 1981: *Suicide Assessment and Intervention,* Baraboo. Sponsored by University of Wisconsin-Extension, Department of Allied Health and University of Wisconsin-Extension, Department of Mental Health. Approved 6 credit hours in Category I of AMA and University of Wisconsin-Extension CEU. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 10, 1981: *Suicide Assessment and Intervention,* Milwaukee. Sponsored by University of Wisconsin-Extension, Department of Allied Health; and University of Wisconsin-Extension, Department of Mental Health. Approved 6 credit hours in Category I of AMA and University of Wisconsin-Extension CEU. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 10, 1981: 25th Annual Clinic Day Program, *Current Advances in Drug Therapy—The New State of the Art,* Milwaukee. Approved 3 credit hours Category I of CME/AAFP. Info: Medical Education Office, St Joseph's Hospital, 5000 W Chambers St, Milwaukee 53210.

NOVEMBER 12-14, 1981: *Current Concepts in Respiratory Intensive Care,* Wisconsin Center, Madison. Sponsored by University of Wisconsin-Extension, Continuing Medical Education; and University of Wisconsin Department of Nursing, Pulmonary Section of the School of Medicine, and Respiratory Therapy Department, and Center for Trauma and Life Support. Approved 18 credit hours Category I of AMA; University of Wisconsin Continuing Medical Education hours; AOA, Family Practice, and College of Emergency Physicians

Medical/Surgical Update '82

TELEMARK LODGE CABLE, WISCONSIN

Wednesday, February 17 - Friday, February 19, 1982

Medical/Surgical Update '82 is designed primarily for general practitioners, family practitioners, general internists and general surgeons. This program focuses on numerous aspects in the fields of medicine and surgery. Various speakers will discuss techniques, problems, innovations and treatments relating to health care.

Registration fee: $125.00
Enrollment is limited to the first 100 registrants. Advanced registration is required; deadline is December 30, 1981.

This program is approved for 9½ hours of prescribed credit from the Wisconsin Academy of Family Practice. It is also approved for 9½ hours of CME Category I credit by the AMA.

A ski package is available for all participants and their families. This package includes a room at the lodge Wednesday and Thursday evenings, downhill and cross country skiing for three days, the use of Telemark's indoor pool, whirlpool and saunas and nightly entertainment.

Sponsors: Marshfield Clinic and Marshfield Medical Foundation

Further information concerning this seminar is available from Marshfield Clinic's office of Medical Education, 1000 N. Oak Ave., Marshfield, Wisc. 54449 or phone 715/387-5207.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
1992—Apr 23-25	

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

credit applied for. Fee: $200 Physician; $130 Nurses, Residents, Respiratory Therapists, and Allied Health Professionals. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 13, 1981: Wisconsin Orthopaedic Society, Olympia Resort, Oconomowoc.

NOVEMBER 17, 1981: *Suicide Assessment and Intervention,* Madison. Sponsored by University of Wisconsin-Extension, Department of Allied Health; and University of Wisconsin-Extension, Department of Mental Health. Approved 6 credit hours in Category I of AMA and University of Wisconsin-Extension CEU. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

NOVEMBER 20-21, 1981: *Boning Up on Tumors of Bone,* Wisconsin Center, Madison. Sponsored by University of Wisconsin School of Medicine, Division of Orthopedic Surgery and Department of Pathology; and University of Wisconsin-Extension, Department of Continuing Medical Education. Approved 11 credit hours of Category I AMA-PRA, American Osteopathic Association Category 2-D, AAFP elective credit, University of Wisconsin Continuing Education credit. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

DECEMBER 11-12, 1981: *Coronary Artery Disease—the View in 1981,* Wisconsin Center, Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Medicine, Division of Cardiology and Department of Surgery, Division of Thoracic and Cardiovascular Surgery, and University of Wisconsin-Extension, Department of Continuing Medical Education. Approved 12 credit hours Category I of AMA-PRA; AOA Category 2-D, University of Wisconsin-Extension, Continuing Education Hours; AAFP credit applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

DECEMBER 14, 1981: *DSM-III: Advanced Clinical Symposium,* Edgewater Hotel, Madison. Sponsored by Continuing Medical Education, University of Wisconsin-Extension; and Department of Psychiatry, School of Medicine, University of Wisconsin. Credit: AOA Category I, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JANUARY 22-23, 1982: *Clinical Genetics for Primary Care Physicians,* Madison. Sponsored by Department of Medical Genetics, University of Wisconsin; and Continuing Medical Education, University of Wisconsin-Extension. Credit: AMA Category I, AAFP, AOA. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JANUARY 18-20, 1982: *New Therapeutics II: The Results of Recent Advances in Medicine,* Telemark Lodge, Cable. Sponsored by University of Wisconsin School of Medicine and Department of Continuing Medical Education. Approved 14 credit hours of Category I of AMA/AAFP. Fee: $215. Info: Ann Bailey, CME, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2854.

FEBRUARY 3-5, 1982: *Ninth Annual North Central Wisconsin Clinical Cancer Conference,* Telemark Lodge, Cable. Sponsored by Marshfield Clinic, Marshfield Medical Foundation, American Cancer Society, Wisconsin Division, Inc, and Minnesota Division, Inc. This program is designed to review medical problems related to cancer and their treatment. Approved 7¾ credit hours of Category I AMA-PRA; 7¾ credit hours WAFP. Fee: $50. Enrollment limited to first 100 registrants. Info: Office of Medical Education, 1000 North Oak, Marshfield, Wis 54449; ph 715/387-5207.

FEBRUARY 25-28, 1982: Wisconsin Psychiatric Association, Lake Lawn Lodge, Lake Delavan.

MIDWEST

NOVEMBER 17-19, 1981 (Michigan): Michigan State Medical Society, Hyatt Regency, Dearborn. Info: W F Tryloff, Director, 120 W Saginaw, East Lansing, Mich 48823.

DECEMBER 9-11, 1981 (Illinois): *Neurology for the Non-Neurologist,* sponsored by Rush Presbyterian-St Luke's Medical Center at Chicago Marriott Hotel, Chicago. AMA Category I credit: 20 hours. Contact: Linda Carter, Office of Continuing Education, Rush Presbyterian-St Luke's Medical Center, 600 South Paulina St, Chicago, Ill 60612; ph 312/942-7095.
9-10/81

OTHERS

OCTOBER 17-21, 1981 (Louisiana): Annual Meeting, American Society of Anesthesiologists, New Orleans. Info: ASA, 515 Busse Highway, Park Ridge, Illinois 60068 (ph 312/825-5586).

OCTOBER 23-25, 1981 (Florida): *Medical staff issues and the practicing physician* seminar by JCAH, at Innisbrook, Tarpon Springs, FL. Registrar: Charlotte Wells, Florida Hospital Association, PO Box 6905, Orlando, FL 32853 (phone: 305/841-6230).

OCTOBER 26-29, 1981 (Georgia): 66th Annual Scientific Assembly of Interstate Postgraduate Medical Association at the Atlanta Marriott Hotel, Atlanta. Info: Interstate Postgraduate Medical Association, PO Box 1109, Madison, Wis 53701.
g9/81

OCTOBER 31-NOVEMBER 5, 1981 (New Orleans, La): American Academy of Pediatrics 1981 Annual Meeting, New Orleans, La. Info: American Academy of Pediatrics, PO Box 1034, 1801 Hinman Ave, Evanston, Ill 60204.

MINNESOTA MEDICAL ASSOCIATION
Resource Group on Rheumatic Diseases
presents

RHEUMATOLOGY SEMINAR IV
and
A WEEK ON CAPTIVA ISLAND, FLORIDA
February 27—March 6, 1982

AUDIENCE: Primary care physicians, orthopedists

CONTENT: Common rheumatologic problems: early diagnosis and the natural course of rheumatic diseases in children and adults, drug management, and surgical considerations with a current update of research in rheumatic diseases.

HOURS: 20 hours, Category I/Prescribed

TOUR PACKAGE: Includes round-trip flight, accommodations for seven nights and car rentals. Depart Twin Cities Airport, February 27; return March 6.

FEES: Educational program-$250; Tour package-from $589/person for double occupancy.

CONTACT: Minnesota Medical Association, Suite 400, Health Associations Center, 2221 University Ave, SE, Minneapolis, Minn 55414; ph 612/378-1875.
9-10/81

OTHERS continued

NOVEMBER 3-9, 1981 (California): American Medical Women's Association, Bonaventure, Los Angeles. Info: L Loesel, Executive Director, 465 Grand St, New York, NY 10002.

NOVEMBER 6-9, 1981 (Nevada): *Medical staff issues and the practicing physician* seminar by JCAH, at Las Vegas, Nev. Registrar: Julie Efaw, Joint Commission on Accreditation of Hospitals, 875 N Michigan Ave, Chicago, IL 60611 (phone: 312/642-6061).

NOVEMBER 10-14, 1981 (Texas): *Cancer 1981/2001—An International Colloquium,* Shamrock Hilton Hotel, Houston, Tex. Sponsored by the University of Texas MD Anderson Hospital and Tumor Institute at Houston. Info: University of Texas System Cancer Center, MD Anderson Hospital and Tumor Institute Texas Medical Center, 6723 Bertner Ave, Houston, Tex 77030; ph 713/792-3030. g9/81

DECEMBER 5-10, 1981 (California): American Academy of Dermatology, San Francisco Hilton, San Francisco. B W Claxton, CAE, Executive Director, 820 Davis St, Evanston, IL 60201.

DECEMBER 8-10, 1981 (Florida): *American Cancer Society National Conference-Gastrointestinal Cancer-1981,* Fontainebleau Hilton Hotel, Miami Beach, Fl. Approved 13 credit hours Category 1 of AMA-PRA and AAFP. Info: Nicholas G Bottiglieri, MD, American Cancer Society, National Conference-Gastrointestinal Cancer-1981, 777 Third Ave, New York, NY 10017.

JANUARY 21-26, 1982 (Louisiana): American Academy of Orthopaedic Surgeons, New Orleans. C V Heck, MD, Executive Director, 444 N Michigan Ave, Chicago, IL 60611.

FEBRUARY 8-12, 1982 (Idaho): *Scientific/Ski Meeting:* The Northwestern Medical Association convenes for its 35th Annual Meeting at Sun Valley, Idaho. Diabetes and related vascular, neurologic, eye, and ENT problems, ski-injury prevention, and high-altitude physiology will be discussed by experts. Approved for 10 CME Category 1 credits. Registration 3 to 5 pm, February 8, Challenger Inn, Sun Valley. Nonmembers registration $100. Info: Norman Christensen, MD, Secretary, 2456 Buhne St, Eureka, Calif 95501. 9-10/81

FEBRUARY 27-MARCH 6, 1982 (Capitiva Island, Florida): 20 hours, Category 1/prescribed. For primary care physicians. Contact Minnesota Medical Assn, Suite 400, Health Association Ctr, 2221 University Ave, SE, Minneapolis, MN 55414, ph 612/378-1875. 8/81

MAY 16-20, 1982 (Brazil): *The Fifth International Symposium on the Prevention and Detection of Cancer, San Paulo, Brazil.* Sponsored by Fundacao "Centro de Pesquisda de Oncologia" and The International Society for Preventive Oncology; Info: Medical Congress Coordinators Department, 1212 Avenue of the Americas, New York, NY 10036; ph 212/840-0110. g8-12/81; 1-4/82

AMA

DECEMBER 6-9, 1981: Interim AMA House of Delegates, Las Vegas, Nev.

FEBRUARY 25-28, 1982: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl. ■

AMA SYMPOSIUM

Diet and Exercise:Synergism in Health Maintenance

NOVEMBER 3-4, 1981
Lake Buena Vista, Florida
(Walt Disney World Complex)

Symposium will focus on the role of nutrition *and* exercise in the promotion of health and the treatment of major health problems. Emphasis will be on the physiologic effects of moderate habitual activity coupled with sound nutrition practices; *ie,* the role of nutrition and exercise in health maintenance and in the treatment of some of our chronic degenerative disease states.

Sponsored by the Department of Foods and Nutrition, American Medical Association, in conjunction with the AMA's Council on Scientific Affairs and Council on Continuing Physician Education, and the Florida Medical Association.

For further information contact: Department of Foods and Nutrition, AMA, 535 N Dearborn St, Chicago, IL 60610.

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Wygesic® ■

MEMBERSHIP FACTS

ARE YOU A MEMBER of the State Medical Society of Wisconsin, or do you know someone who isn't? Whether you're just starting medical school, maintain a full-time practice, or are retired, SMS has a membership classification to fit your individual needs. Furthermore, in light of a recent change in membership policy, physicians may join their county and state societies and the AMA or just their county and state societies; however, AMA membership is encouraged. Dues for regular membership are $410 for SMS, $285 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF DUES CLASSIFICATION CODES

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of illness or financial hardship. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: Member who is engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy.

Emeritus: Retired members who have chosen not to renew their license.

1982 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$410	$285	Normal County Dues
Resident	41	35	Varies
Military Service	-0-	285 or 35	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-	-0-
Honorary	-0-	-0-	-0-
Retired	-0-	-0-	-0-
Part-time Practice	205	285	Normal County Dues
Over Age 70	205	-0-	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-	
Candidate—			
Freshman Year Medical Student	-0-	15	?
Sophomore and Succeeding Medical Student Years	10	15	?
Postgraduate—One	10	35	?

15 MONTHS FOR THE PRICE OF 12!

In light of the recent change in membership policy allowing physicians to join their county and state societies and the AMA, or just their county and state societies, physicians are encouraged to join organized medicine now. Regular membership dues for 1982 are: $410 for SMS, $285 for AMA, and county society dues vary. However, physicians who join now will not pay any dues for the balance of 1981. That's 15 months for the price of 12! Membership applications may be obtained by contacting the secretary of your county medical society or by calling Mike Brozek at the State Medical Society offices in Madison at 608/257-6781 or toll-free: 800/362-9080. ■

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

COSTS OF REGULATING HEALTH PROFESSIONS SUBJECT OF STUDY. The State of Wisconsin is launching a study to determine costs to consumers for state regulation of the health professions. Ann Haney, secretary of the Dept of Regulation and Licensing, says a 25-member task force will be formed and will include a representative for each of the nine regulatory boards in the health professions. Haney says that her aim in conducting the study is to get the various professions to "square off" and ultimately produce deregulation or at least more reasonable regulation of the professions.

CHIROPRACTIC DEVICE USELESS, COURT RULES. US District Court ruled in September that a chiropractic tool leased to more than 700 chiropractors in the country as an aid in diagnosing spinal problems doesn't work. The Consumer Affairs Section of the US Justice Departments' Antitrust Division has announced it will seek a permanent injunction to prevent further distribution of the device known as the Toftness Radiation Detector. Toftness of Cumberland, Wisconsin invented the device and has offered instructional classes on how to use it at the Toftness Post-Graduate School of Chiropractic, Inc in Cumberland.

CONSUMER COST CONTAINMENT BROCHURE OUT. "Health Care Costs: What Can You Do?" is a new brochure published by the Voluntary Effort to Contain Health Care Costs. It suggests a number of steps consumers can take to hold down costs, such as attempting to stay out of the hospital when outpatient or home care alternatives are possible, following good health habits, asking questions about their care and their bills, and determining what their health insurance covers. Single copies of the brochure may be obtained by sending a self-addressed, stamped #10 envelope to Voluntary Effort, 840 N Lake Shore Drive, Chicago, IL 60611. Lots of 100 may be purchased for $15 and bulk rates are available.

MEASLES—ELIMINATED?. The Division of Health has confirmed the second case of measles this year. This compares with 140 cases in this same period last year. Last year was the first time that all school children were required to be immunized or provide religious or personal conviction grounds for an exemption. Both cases this year occurred when Wisconsin residents traveled outside the state and returned with an active case.

CPT-4 UPDATE AVAILABLE. Over 60 revisions are included in the Sixth Update to the Fourth Edition of the Physicians' *Current Procedural Terminology*, the American Medical Association's comprehensive system for naming, coding, and reporting medical procedures and services. The CPT-4 text and future CPT Updates will be available through the Order Department, American Medical Association, PO Box 821, Monroe, WI 53566. Single copies of CPT-4 (OP-041) are $19.95 each plus $2.00 for postage and handling or $3.00 for delivery via UPS. Single copies of the Seventh Update (OP-097) will be $5. (Updates First through Sixth will be provided free of charge). Orders should be prepaid.

MANDATORY CHILD PASSENGER PROTECTION LAWS PASS IN EIGHT STATES. Eight states now have laws requiring that children below a specified age be protected by federally-approved restraint systems while being transported in motor vehicles. Kansas, Michigan, New York, Minnesota, North Carolina, Rhode Island, Tennessee, and West Virginia currently have child passenger protection laws, while California and Maine have laws calling for public information programs to encourage seat restraints in children. In Wisconsin a bill (AB 600) which would make such restraint systems necessary for under four years of age is currently in the Assembly Children and Human Development Committee. SMS supports the bill. ■

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WISCONSIN MEDICAL JOURNAL

NOVEMBER 1981

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- "New Horizon" nurse
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- Impaired physician report
- Dispensing medication in schools

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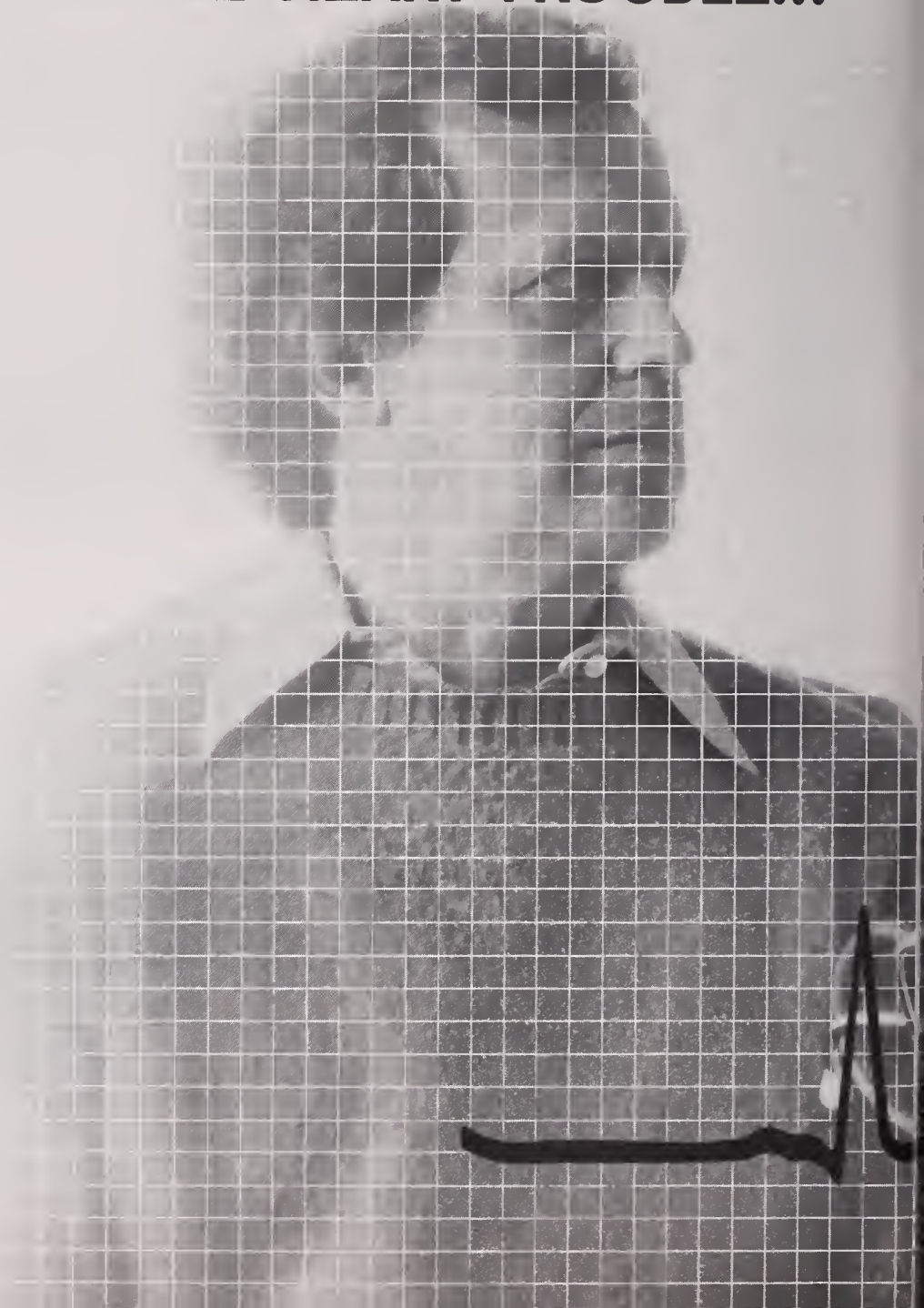

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CORRECTION: In the September 1981 issue there is an error in the article, "Computed tomography of the lumbar facet joints," by Boedecker, Kim, and Nix. On page 21 the illustrations are transposed, thus the illustration above Figure 1(b) is actually Figure 1(a) and the illustration above Figure 1(a) is actually Figure 1(b). The *Wisconsin Medical Journal* and its printer apologize for this error.

WISCONSIN MEDICAL JOURNAL (ISSN 0043-6542) is the official publication of the State Medical Society of Wisconsin, devoted to the interests of the medical profession and health care in Wisconsin. Its affairs are handled by the Editorial Board, subject to policy direction of the Council. The Managing Editor is responsible for the production, business operation, and coordination of contents as well as the final responsibility of the entire publication. The Editorial Director is responsible for Editorials. In Editorials, official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the Journal. Indexed in "Index Medicus" and "Hospital Literature Index." Contents page included in "Current Contents/Clinical Practice."

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Physician placement directories published

Physicians and medical facilities now have help from the American Medical Association in filling their placement needs. The spring quarterly issues of both *Physician Placement Register* and *Opportunity Placement Register* are now available through the AMA's Physicians' Placement Service.

The Registers, one listing available physicians and the other current vacancies, are cross-indexed by medical specialty, type of practice setting, state, and size of community. Also available are separate listings of part-time and *locum tenens* positions and available physicians and a register of overseas opportunities.

The Physicians' Placement Service was established in 1944, and serves as a national resource, crossing both specialty and geographic lines.

There is a one-year registration fee for physicians of $35. AMA members receive a $10.00 discount. Hospitals and other medical facilities are charged an annual registration fee of $95. To receive a free copy of either Register, write to Physicians' Placement Service, American Medical Association, 535 N Dearborn Street, Chicago, IL 60610; or contact Michael P Muckian (312) 751-6594.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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President's Page

ALBERT J MOTZEL JR, MD

Some final thoughts regarding fees

WHILE THE possibility of returning to an indemnity fee schedule has received positive consideration in many discussions with physicians during the last six weeks, there are some perceived inequities in present fee structures that would not be corrected by the initiation of this mechanism alone—at least not in the manner suggested. Among the inequities, frequently recognized and mentioned even by those to whom they would seem advantageous, I would like to submit three or four for consideration.

There is a generally recognized disparity between the compensation of the cognative specialties and the manipulative specialties based on time spent in care. This may not be specialty-related as much as perhaps to the easy recognition of the procedure itself, for it seems true of those manipulative procedures that fall within the province of medical specialties as well as surgical specialties. Nevertheless it is aggravated by some significant fees for short, well-defined procedures that ordinarily require minimal cognative postoperative care in their own right but frequently involve dependence on the care by a medically-oriented physician for both evaluation and care of some complex cardiorespiratory problems.

A similar disparity exists when similar or identical procedures are performed by physicians in both broader and more narrowed specialty fields. In some instances even the generic question of what is a "major" and what is a "minor" procedure becomes confused in this area. If this problem is to be solved through uniformity of fee structure, the establishment of competence to perform specific procedures will require increased attention from the profession.

Another area generally conceded to require attention is that of the "new" procedures introduced in the last 20 to 25 years. These procedures were "new" in the sense that they were not simply improvements on older techniques for doing long-standing procedures, but represented entirely new possibilities for benefiting patients based on discoveries or refinements in immunology, metallurgy, instrumentation, prosthetic materials and the like. The procedures were "new," high-risk, experimental, and were initially performed by a creative vanguard of specialists responsible for the assembling and training of highly developed support teams. Significant compensation was allowed for these procedures under such circumstances. But circumstances have not remained the same—many of these procedures have become, if not routine, certainly commonplace. The circumstances under which they are performed and the time necessary to perform them have changed dramatically and yet the relative fee initially allowed has not been re-evaluated.

A related area is that in which multiple procedures are the result of our present ability to perform operations that often increase peripheral blood supply and preserve extremities. Our ability to perform these procedures, for now, exceeds our ability to predict the success of such procedures. This is a difficult dilemma in an era of "free" care, since to the patient the hope for success is often far out of proportion to the risk. Again a justifiable but significant cost can be generated without change in the final outcome.

Lastly, assuming solutions to these and probably other difficult problems requiring almost infinite goodwill, patience, negotiations, and selflessness on the part of all concerned—and assuming that some limited trial of indemnity schedules would prove successful—can these things be accomplished quickly enough to prevent less desirable trends in patient care? Even if so, we will still be faced with the problem of how to regulate the care of the truly indigent to whom personal economic involvement is probably not realistic.

Realizing the disruptive potential, not to mention the legal questions involved in our Society's approaching this subject in a serious way, I can see no alternative to accepting the risk and responsibility for the sake of the continued excellent and affordable medical care for the citizens of this state and country. ■

Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Fireworks

STATE SENATOR FRED RISSER of Madison has been working on legislation to strengthen the present law regulating the sale and possession of fireworks in Wisconsin. He has been aided in writing Senate Bill 300 by numerous concerned agencies such as law enforcement officials, fire personnel, district attorneys, and representatives from the State Department of Agriculture, Trade and Consumer Protection.

The present law, which dates back to 1947, is considered unworkable and ineffective. The old law was based on the chemical composition and designated contraband fireworks. Since that time the composition of fireworks has changed and there are now more powerful and sophisticated compounds and mixtures that are not banned under the old law.

Mention of the particular year of 1947 recalled my experience on the Fourth of July of that year. I had a half day off from my residency because of the holiday and had come back to Wisconsin for a brief visit. The entire afternoon was spent in surgery trying to repair a young man's hand that more closely resembled hamburger. He had placed a cannon cracker in a piece of metal pipe and had held it in his hand when it exploded.

There is absolutely no reason for accidents of this sort or any of the other 8000 injuries treated in hospital emergency rooms across the country every year due to fireworks and related injuries.

Senator Risser points out that of the number of injuries more than a third of the victims are under the age of 12. In addition to the injuries and property damage in 1980 there were three fireworks-related fatalities in Wisconsin. Two of these were firemen killed in the line of duty and the other was a teenage boy.

Organized medicine should give every support to Senator Risser in the passage of this legislation.

—VSF

Harry Beckman, MD: 1892-1981

HARRY BECKMAN died in his sleep at his home in Center Sandwich, New Hampshire on September 16, 1981. The Beckmans had moved to New Hampshire in 1971, and although Doctor Beckman made no further contributions of consequence to medical literature after that, he had maintained a characteristically busy daily work schedule setting aside several hours each day to writing, at least until last winter when he was injured in an automobile accident, and from which he never fully recovered.

Any Wisconsin medical student or physician from 1925 to 1970 will remember Harry as an excellent Professor of Pharmacology at Marquette, as a careful researcher on varied medical subjects, as a medical writer who wrote with style as well as accuracy, and as the author of the most popular medical textbook published by Saunders in the 1930s and 40s (Treatment in General Practice).

Readers of the *Wisconsin Medical Journal* knew him as the Journal's steadiest contributor. He wrote many scientific articles for publication therein and also edited regular features such as "Comments on Treatment" and "Therapeutic Dilemmas." Needless to say material submitted by him required very little editing.

Harold Hardman, MD, his successor at Marquette, wrote a biographical sketch, "Tribute to a Retiring Editor," on Doctor Beckman for publication in the *Wisconsin Medical Journal* in 1962. It was reprinted in the 1967 Festschrift dedicated to Doctors Beckman and Quick. It is worth re-reading.

But those of us lucky enough to have been on the medical staff at Columbia Hospital in the 1960s will have the fondest Beckman memories of all. For when Doctor Beckman retired at Marquette, he moved his extensive library and green eye shade to Columbia and just kept right on going, developing the medical library there to levels far beyond those seen in the usual community hospital. He became the consultant and confidant to the entire staff, adding a great deal of professionalism and quality to continuing medical education efforts at all levels. There he remained for nine years until the final move to New Hampshire.

Harry didn't believe in the Hereafter—at least he said he didn't the last time we talked about it. Perhaps he was just too much a scientist to accept on faith what could not be demonstrated by the experimental method. Maybe that's why he lived as he did, with an intense urge to keep on producing to the maximum of his ability—as though this one opportunity was all there was going to be. But produce he did, continuing on long after failing eyesight and hearing made his labors difficult indeed. And we all profited from it. Somehow I can't help feeling that right now he's sitting somewhere with that green eye shade and writing furiously in that partially legible script of his recording the accuracy of that last hypothesis—and wondering how to get it published. May the Editor be merciful. —WJB

Bipartisan deregulation

IN SEPTEMBER a bipartisan (four Democrat, six Republican sponsors) bill was introduced to repeal the National Health Planning and Resources Development Act in September 1982.

Representative Shelby (D-Alabama) stated that it was clear that the health planning program had failed and that the law should be repealed. "The result of the law has not been planning, but regulation." "The predominant activity is the certificate-of-need process which is not a planning tool but a means to control the health care system," Shelby added.

Any measure that will result in deregulation is legislation in the right direction. This bipartisan awareness and effort deserves our commendation.

—VSF

Lilliput-putts

SAVING GAS, but losing lives! That is what has happened with the increase in small, energy-efficient cars. According to the *Journal of American Insurance,*[1] the statistics coming in indicate that there are serious problems for occupants of small cars.

For example, subcompact cars accounted for 6573 highway deaths in 1979, a higher number than for any other size vehicle. Even though small cars made up only 38% of the cars on the highway in that year, small-car occupants accounted for a disproportionate 55% of the deaths in two-vehicle crashes.

When a subcompact car collides with a large car, the chances of the occupants of the small vehicle being killed are eight times greater than for those occupants of the large car. Even in a collision between a compact and a subcompact car, the chances of being killed in a smaller car are three times as great.

The statistics aren't much better where small single-vehicle crashes are concerned. Again in 1979, 51% of those car occupants killed in single-vehicle crashes were riding in small cars, although the small cars accounted for only 35% of the cars on the road at that time.

The reasons why small-car occupants are hurt in crashes lie in the physical laws of mass, motion, and acceleration that safety experts have long pointed to with alarm. A small lightweight vehicle simply has less physical structure available to absorb the forces created by a car crash. It has been found that once cars are downsized to 3000 lbs every additional 100-lb decrease in weight also diminishes the crashworthiness of the vehicle by at least 5%.

There is also generally less "survival space" in smaller cars. This means that in the smaller cars there is not enough room inside the car. In a crash the occupants are more likely to be thrown into the dash board or crushed by buckling metal. A smaller car simply cannot protect its occupants as well as a larger one.

Another factor is that most US highways were built long before small cars became so popular. Consequently, the sign posts, light poles, and other supports and barriers which were built to breakaway when hit by a standard-sized car, may not break when hit by a smaller one. These are constructed to present little or no hazard to a 4000-lb car, but can seriously damage a 2000-lb vehicle and consequently injure its occupants. Also, the standard concrete barriers designed to deflect a 4000-lb car may cause a smaller vehicle to flip and roll. In highway construction the curves, hills, and no-passing zones were designed for larger vehicles. Not only is it difficult to see a smaller car but also it is more difficult for small-car drivers to see. Highway design standards for a safe stopping or passing-sight distance are based on an average driver's eye height of 45 inches. However, typical driver eye height in a small car varies from 36 to 41 inches. This is especially important in seeing over the top of a hill or around a curve.

In California it was found that highway fatalities occurred twice as often on the crest of up-hill curves as they do the bottom of them. Wind is also an important factor in controlling a small car, especially at high speeds. Unexpected cross winds or the rush of air caused by a passing trailer-truck or bus could actually blow a boxy small car into another lane. Rear engine models are particularly liable to cross winds and head winds which may cause these cars to pitch. Front engine cars, especially front-wheel drive cars, track best under windy conditions.

The National Highway Traffic Safety Administration lists the odds. Each person in this country can expect to be in a car crash every ten years, on the average. One out of every 60 people born will die in a car crash and one out of 20 will be seriously injured. The drivers of small cars run the risk of death or injury twice as high as the driver of large cars. Is the trade-off in safety worth the saving in gasoline?

Thus, small car drivers need to be extra cautious on hills and curves. The drivers must also familiarize themselves with four- or five-speed transmissions since automatic transmissions have been popular. It has been shown that a small car is much more visible if it is a light color. A car painted yellow, or another light color, can be seen two to four times farther away than a dark colored one in a fog, hard rain, or twilight. It is also crucial that the 55-mile per hour speed limit be observed whether the vehicle you are driving is large or small. The importance of seat belts is even greater in small cars. The risk of death or injury is increased by a factor of five by not using seat belts compared with using seat belts in a larger car. —VSF■

[1] *Journal of American Insurance,* Spring 1981.

Letters

The Editors would like to encourage physicians to contribute to the LETTERS section where they can ventilate their frustrations as well as opinions. This feature is intended to be lively and spirited as well as informative and educational. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address correspondence to: The Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis 53701.

Workers' compensation

TO THE EDITOR: In a recent article in the *Wisconsin Medical Journal,* July 1980: Volume 80, P. 25, Mr John Byrnes, Administrator of the Workers' Compensation Division, is quoted as having "a shopping list" of complaints his agency has experienced. These include complaints concerning a four-day evaluation for patients admitted to the Industrial Injury Clinic in Neenah; finding physicians to offer a tie-breaking opinion between company physicians and employee physicians concerning length of healing process; and lastly the problem of opinions by physicians who are pro-insurance company or pro-plaintiff attorney. I feel Mr Byrnes is correct in his complaints, and that the whole problem of Workers' Compensation needs a fresh look.

Some patients' complaints and findings are very clear and easy to evaluate; *ie,* visual impairment, fractures with specific limitation of motion, and amputations. The problem arises when a patient has complaints that are disproportionate to any objective findings. It is here that we have differences of opinions in regard to diagnosis, treatment, work restrictions, return to work and disability ratings. We, as physicians, have been trained to make a diagnosis so that the insurance record, hospital record, and office record are complete. This is simple when we can agree, and we do agree when tests and examinations are irrefutable, such as in diabetes mellitus, carcinoma of a particular organ or fracture, but there are a host of complaints that patients have that defy a precise diagnosis. This leads to a wastepaper basket type diagnosis such as cervical or lumbar muscle strain, whiplash injury, post traumatic headaches, low back fasciitis, lumbodorsal tendinitis, and facet syndrome. One patient may have many of these labels because we as physicians do not agree on what these diagnoses mean medically or pathologically. The patient, who is the one we should be concerned about, is now treated like a ping-pong ball by the doctors, insurance carriers, employers, and attorneys. No wonder the patient becomes confused and anxious.

This cast of characters is all wittingly or unwittingly pushed by events that are dictated by money. The insurance company wants to save money, the plaintiff's attorney wants the most he can get for his client so that he can make as much as he can, the employer wants to save on premium costs and get the case solved, and the doctors are pushed by one side or the other to give an appropriate opinion. It is no secret that an attorney can send a patient to a specific doctor because he knows that the doctor to whom he sends the patient will probably send him a favorable report. Furthermore, if it should happen that a written report is unacceptable to either party involved, they just turn around and seek another opinion, hopefully to their liking. Thus the patient is a pawn that is manipulated by the legal and insurance systems.

It is no wonder that the workers' compensation judges don't know what or whom to believe. The problems are:

1. Lack of knowledge on the part of physicians of workers' compensation laws and the Kirschener Act. Some of these laws are poorly written and nonspecific, and physicians have had no or very little exposure to them.
2. Lack of empathy for patients on the part of the employer, the attorney, and the insurance carrier. This leads to the playing of ping-pong with patients which fosters misunderstanding and leads to diverse medical opinion and conflicting reports.
3. The lack of cooperation between the various parties mentioned.

To correct the above, I believe that:

1. The workers' compensation laws should be carefully looked at and meaningfully reformed by a panel composed of legislators, employers, insurance company representatives, lawyers, and physicians.
2. Limit the number of "evaluations" that a patient has to undergo.
3. Make it worthwhile for industry or the employer to help in the rehabilitation process of the employee and also to make it more profitable for the employee or patient to return to work rather than collect disability and not work.
4. Have physicians make diagnoses that are as specific as possible and that mean the same to everyone including the patient.
5. Bring to the awareness of physicians a list of meaningful restrictions that he may place upon the patient compatible with a specific diagnosis.
6. We should come up with realistic and uniform disability ratings for those patients who have complaints that are disproportionate to objective findings. This by definition would include a disability rating for pain.

7. Divorce rehabilitation and vocational impact from the physician's report since he is not a rehabilitation or vocational expert. The experts who do that are trained in their fields and can use the doctor's restrictions and disability rating as a framework for their opinions.

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Editor's note: Doctor Suechting formerly was associated with the Industrial Injury Clinic and is now with the Fox Valley Neurological Associates. John Byrnes has recently become US Attorney in Madison. Succeeding him as administrator of the Department of Industry, Labor and Human Relations' Workers' Compensation Division is K Sue Mattka of Whitehall. See separate story elsewhere in this issue.

Infant safety program

TO THE STATE MEDICAL SOCIETY: I was delighted to receive the generous check of $500 from the Charitable, Educational and Scientific Foundation of the State Medical Society. It will alow us to help start some car seat educational loaner programs in the state, modeled after the Madison KISS (Keep Infants Seated Safely) Program. We are particularly anxious to initiate programs in the northern tier of the state, where considerable interest has been expressed. It has been a wonderful experience for me to witness the enthusiasm, including monetary support, the Medical Society at both the state and local level has given our attempts to change motor vehicle death and disability in the infant. I am singing your praises at every opportunity.

Kathryn P Nichol, MD
American Academy of Pediatrics
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Holistic medicine

TO THE EDITOR: I feel compelled to reply to Doctor Kabler's commentary in the September 1981 *Wisconsin Medical Journal.*

Holistic Medicine does not "uncritically incorporate. . .philosophies. . .as astrology, Oriental mysticism. . .as well as prescientific notions and nostrums. . ." There are people, of course, who claim to practice holistic massage, which I presume means massage of the whole body. But that is not Holistic Medicine. Those physicians who have looked at Holistic Medicine from a more realistic point of view have really not endorsed or taken up such things as iridology, reflexology, etc. There may be individual practitioners who push those, but not those who have looked at them long enough to recognize how irrational they are.

The American Holistic Medical Association has emphasized that there are nine major fields which need to be examined in addition to traditional drugs and surgery. These include nutrition, physical exercise, mental self-regulation (biofeedback, etc), neuromuscular integration (osteopathic manipulative therapy and other postural adjustments), environmental medicine, bimolecular medicine, behavioral medicine, acupuncture, and spiritual attunement. All of these fields have elaborate scientific work done. They are being studied further, with excellent scientific work going on in each of these fields. They are being researched and evaluated at numerous medical schools throughout the country. Unfortunately, as often happens with a new concept, a lot of people jump on the bandwagon; but anything you call a system is likely to be prostituted by the fringe. That certainly does not mean that the concept of comprehensive evaluation of the total person is wrong or even controversial. It is the foundation of truly good medical practice.

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Intracoronary thrombolysis

TO THE EDITOR: I read with considerable interest, the article appearing in the *Milwaukee Journal* of October 7, 1981, entitled "Physicians Test Heart Treatment," which outlines treatment for acute coronary thrombosis using streptokinase.

Having participated in the Urokinase Pulmonary Embolism Trial, the Urokinase-Streptokinase Pulmonary Embolism Trial, and the Streptokinase-Urokinase Myocardial Infarction Trial as a principal investigator, I am not unfamiliar with the use of lytic agents. They were described in the article as anti-clotting agents, but are, indeed, not anti-clotting agents, but rather lytic agents which dissolve clots.

I do, however, advise the medical community to view this work with extreme caution in that there is no reason to believe that this treatment has shown cause and effect. Specifically, there is no reason to believe that streptokinase dissolves the clot identified by arteriography. It would require a double-blind, randomized trial with one agent being a placebo and the other being a lytic agent for scientific validation. It is well known that not all people who have anginal attacks proceed to myocardial infarction. Those who progress to the so-called intermediate syndrome may have platelet thrombi that sometimes spontaneously fragment, which likely is the reason not all people

with the intermediate syndrome suffer myocardial infarction. It is possible that the simple injection of any material (saline) might fragment a clot. Another confounding factor is the work of Spain which implied thrombosis occurred after myocardial infarction.

Experience obtained in the randomized trials using lytic agents indicates that lysis probably does not occur for several hours (perhaps even 24 hours) from lytic therapy in the treatment of pulmonary embolism with a full therapeutic dose, converting all or nearly all of the plasminogen to plasmin. It is hard to believe that a small dose of the agents administered directly above the clot would have a lytic effect. No difference was experienced between the infusion of lytic agents into the pulmonary artery or into the peripheral vein for the treatment of pulmonary embolism.

Angioplasty using a balloon catheter is an advance in the treatment of coronary artery disease. Though it is not specifically stated in the newspaper article, only a very few people are candidates for this procedure. The lesion has to be accessible, which means it must be proximal in the anterior descending or right coronary artery and the obstruction must be quite short. From the medical literature, it seems common practice to have a heart surgery team standing by while this treatment is administered as it is hazardous.

The timing process, I would agree, is critical, but the information that myocardial necrosis usually occurs within six hours after a heart attack seems to be quite a generous time frame. It is well known that ligation of the anterior descending artery in a dog causes tissue necrosis after 20 to 30 minutes. Certainly those with coronary artery disease do have collateral blood supply; it is equally certain that no one knows the exact amount of time necessary for necrosis to occur in a person who has preexisting coronary artery disease. The time frame is most likely less than one hour for tissue necrosis to occur following the occlusion of a major coronary artery.

Finally, it is unfortunate that this sort of information goes to the lay press rather than to scientific journals as it raises many false hopes and is misinterpreted by the vast majority of readers. The only apparent motive is self-aggrandizement, and as such, this practice should be discouraged by the medical profession.

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Commentary BY A SENIOR PHYSICIAN

The "New Horizon" nurse and the physician

A need for guidelines. . . **Ewald H Pawsat, MD,** Fond du Lac, Wisconsin

IN AN ERA OF unbridled societal change, which has profoundly affected our professions of nursing and medicine both by external influence and internal direction, there all too frequently has been a lack of proper accounting as to what these changes represent in the way of personnel, time, cost, interprofessional relations, and more importantly, demonstrable improvement in patient health and welfare.

The purpose of this paper is to comment on hospital observations made in this regard over the last decade or so, particularly with relevancy to interprofessional relationships.

Hospital administrators, who monitor our joint workshops, should be acutely aware of the growing overlap of patient care in the medical, nursing, and allied healthcare fields. They should also fully recognize the potential for conflict if patient care in the hospital setting is not further defined as to authority and responsibility by professional guidelines.

As physicians and nurses, we should demonstrate concern when changes, through unilateral direction of our professional goals, lead to a growing-apart of our professions. Many factors have contributed to a gradual, though significant, erosion of interprofessional harmony. A few major factors should be pointed out.

Over the years, physicians have increasingly relinquished supervision of their hospital patients by failing to take seriously the important differences between delegating, relegating, and abdicating medical responsibility. Also, the marked trend to medical specialization and, generally, a more comfortable and casual approach to practice has led to fragmented patient care with resultant default, on the part of the physician, towards the patient's total welfare. Quick to appreciate these voids in patient care, the nursing profession and the allied healthcare personnel have stepped in, but in so doing they have added other dimensions to the fragmentation of patient care and a very real potential for competitive hospital patient supervision.

Another significant factor in our professions' growing-apart has been the gradual phasing-out of physician participation in the nursing program. The physician is no longer considered essential as a consultant in nursing education curriculum building. His role as a formal lecturer or as ward instructor in the training of nurses has been eroded. This lack of physician contribution to the overall nursing program has become acutely apparent in the nurse's more independent approach to the hospitalized patient's care.

The hospital setting itself, with an ever-increasing unilateral departmental nursing administration, has become too nursing oriented, too dictatorial in the direction of patient care with a growing concurrent negative attitude toward physician input and cooperative effort. This situation creates a dilemma when it seriously questions the physician's ultimate responsibility for the medical care of the hospitalized patient. As a result, there are frequent, often ethical, breaches of good healthcare practices by over zealous nurses. These become especially disturbing incidents when nurse personalities and philosophies counter the attending physician's handling of the patient.

In my opinion, however, the major factor in creating a disturbed interprofessional relationship is the complexion of "New Horizon" nurses and the direction of their efforts in hospital patient care.

Current nursing philosophies, teachings, and practices appear to reflect a struggle for identity and recognition as professionals on the healthcare team. There have been efforts in the recent past to phase out hospital-based diploma programs and practical nursing programs and to introduce the baccalaureate degree as the minimum requirement for the "professional" nurse practitioner of the future. Reaction to this goal has lead to intraprofessional turmoil, which is the result of the unresolved problem of finding the proper niche for the degree nurse, the diploma nurse, the associate degree nurse, the practical nurse, and nurse aides in the scheme of hospital patient care.

Many physicians are not fully aware of the recent past and current trends in the philosophies and the direction of nursing education and practice.

There is no objection to nurses' pursuit of knowledge in their field. Serious questions must be raised, however, when the breadth of diagnostic and therapeutic teachings in the basic nursing curriculum instill in the student and the inexperienced nurse a

sense of competency to make decisions in these areas. There is no quarrel with the vast majority of nurses who continue to practice and pursue postgraduate advancement in the traditional role of nursing. Their services in support of the medical profession towards good patient care are vital and much appreciated. Physicians recognize as well that nurses can develop expertise, through postgraduate and specialized training, towards an independent approach to the provision of healthcare. Whereas this is possible, practical, and legal in such areas as public health, the nurse practitioner field, nursing home facilities, and other specialized and independent fields, this approach cannot be generally implemented in the hospital setting if the physician is to continue to have the primary responsibility for the patient's healthcare. Furthermore, physicians need and encourage the development of nurses expert in their fields through postgraduate education, training, and experience, who under their direction and guidance, assume responsibilities in the medical field which formerly were in the realm of the physician.

There is, however, especially in the baccalaureate degree program, evidence that nurse education, training, and practice is more and more being directed into the medical field without due consideration as to how this direction may influence interprofessional relationships.

Altruistic as the nursing profession's aims towards increased responsibility for healthcare provision may be, it is imperative that concurrent guidelines be established as to what is legitimately nursing practice with careful participation in the gray areas which border on the practice of medicine and noninvolvement in the medical field.

Some recent major trends towards change in the nursing profession have not demonstrated interprofessional consensus. Unilateral professional aspirations have not always been delegated to a secondary role in considering hospital patient welfare. There has been a lack of communication and collaboration with the medical profession in this area of healthcare. As a result, there is evidence that current nursing education, nursing practice, and related disciplines seek to build a "New Horizon" nurse that is competitive rather than supportive to the physician.

With this type of indoctrination, some members of the nursing staff tend to feel that they not only have the "right" but also the "responsibility" to be the hospital patient's advocate in all health matters including recommendation for consultation, second opinions, discussion of alternate therapies, and independent documentation of history and physical findings, formerly strictly in the domain of the physician.

Small wonder that student nurses, with their inordinate preoccupation with the stethoscope and PDR, will freely question the diagnosis and therapy of physicians when they are legally and professionally unqualified to make a diagnosis or prescribe therapy, and medicolegally at risk if they do.

With increased staffing of hospital departments by baccalaureate degree nurses and "New Horizon" teachings on the floor by advanced degree nurses, the patient is exposed to independent viewpoints and decisions, not always limited to nursing care and, therefore, in potential conflict with the medical management of the patient by the physician. Truly, the physician, and at times the patient as well, may question whether our institutions of higher learning and their departments of nursing are turning out a hybrid-type of healthcare person who is a meld of doctor and nurse. These individuals pose a problem for both professions and the patient since their field of operation in the hospital setting has not been

EWALD H PAWSAT, MD—As one of Wisconsin's senior physicians, Doctor Pawsat has served the medical community in an exemplary capacity during his almost 50 years of practice. Born in 1908 in Sheboygan, he went on to graduate from the University of Cincinnati College of Medicine in 1932. He took his internship at St Agnes Hospital in Fond du Lac and completed pediatric training at Bellevue Hospital, Children's Service, New York City, and Portsmouth Naval Hospital, Portsmouth, Virginia. He served in the United States Navy as Lieutenant Commander, 1942-1946, and was awarded the Bronze Star Medal. Doctor Pawsat was the first physician in Fox River Valley to limit his practice to pediatrics. Active in organized medicine, Doctor Pawsat is a past president of the Fond du Lac County Medical Society and served over the years on a number of committees of his county society, the State Medical Society, and the American Medical Association. He also is a past chief of the medical staff of St Agnes Hospital, Fond du Lac. Doctor Pawsat was a member of the State Medical Examining Board, 1955-1959, and was a member of President Dwight D Eisenhower's Advisory Committee on Fitness of American Children and Youth, 1958-1959. He served on the AMA Council on Voluntary Health Agencies, 1964-1973. Having held offices and been a participant in community organizations, Doctor Pawsat earlier this year was the recipient of a Community Recognition Award by the Fond du Lac Area Association of Commerce for his outstanding and dedicated service to his profession and community.

DOCTOR PAWSAT

clearly defined as to need, integration, and scope of responsibility.

Envision potential for dilemma if personnel from other services in the hospital such as laboratory, x-ray, pharmacy, physical therapy, and diet therapy seek an equally direct approach to patient care without the consent, direction, and supervision of the physician.

The writer makes these observations after almost 50 years of medical practice. Participation, for many years, in the formal teaching and training of both student and graduate nurses is recalled with nostalgia. Medical input opportunity in the past by personally serving on a nursing school committee was, in my opinion, a great opportunity for building interprofessional harmony and understanding. In more recent years, serving on the board of trustees of an institution of higher learning with a department of nursing allowed for close monitoring of the nursing program and the resultant concern about its direction.

It is my hope that the above viewpoints do not reflect senility, delusion, or paranoia, although a considerable degree of intolerance to unwarranted, unproven, and unacceptable change is freely admitted.

My family of four children, who, together with their spouses, include three nurses representing both diploma and degree training, a dentist, and three physicians, are a source of pride and respect for the health professions. Their input for this discussion, not always in total agreement, has been appreciated.

In closing I will quote Shakespeare in defense of my position: In *Taming of the Shrew* he wrote, "I speak but as I find."■

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Blue Book–Update

IN THE LISTING on page 97 of the June 1981 *Blue Book,* under Medical Examining Board, the following changes should be made: George Wm Arndt, MD, Neenah, succeeds Rudolf W Link, MD, Madison; Susan F Behrens, MD, Beloit, succeeds W Dudley Johnson, MD, Milwaukee; and reappointed to another term was Nelson A Moffatt, MD of Marshfield. ■

Guideline admission criteria for chemical dependency treatment services

THE STATE MEDICAL SOCIETY Committee on Alcoholism and Other Drug Abuse has developed with the approval of the SMS Board of Directors, guideline admission criteria for the following chemical dependency treatment services:

(1) Detoxification
(2) Inpatient Evaluation and Rehabilitation
(3) Outpatient Treatment

DETOXIFICATION

Admission to the hospital depends on the presence of one or more of the following:

1. Presence of a clustering of withdrawal symptoms (not all inclusive):
   (a) tremulousness (inner/outer shakes)
   (b) insomnia
   (c) irritability/restlessness
   (d) vague somatic complaints
   (e) nausea, vomiting, diarrhea
   (f) diaphoresis
   (g) headaches
   (h) abnormal vital signs
   (i) mental confusion/fluctuating orientation
   (j) hallucination, hallucinosis
   (k) psychoses
   (l) seizures
   (m) delirium tremens
   (n) stupor
   (o) rhinorrhea
2. Presence of associated medical problems.
3. Suspected alcohol and drug dependency.
4. History of withdrawal syndrome.
5. History of prolonged intoxication.
6. Signs and symptoms that may be due to specific chemical dependency, not listed above, but recognized by the physician.

INPATIENT EVALUATION AND REHABILITATION

Admission to the inpatient program depends on medical stability, the absence of acute withdrawal symptoms which may interfere with rehabilitation (and/or completion of detoxification), and the presence of one or more of the following:

1. Need for environmental control.
2. Need for 24-hour behavioral monitoring and confrontation.
3. Counterproductive medical or psychosocial situation.
4. Presence of a clustering of the following:
   (a) Neurological psychological symptoms
      —denial
      —anguish
      —mood fluctuations
      —over-reaction to stress
      —lowered stress tolerance
      —impaired ability to concentrate
      —limited attention span
      —high level of distractability
      —extreme negative emotions
      —extreme anxiety
      —extreme depression
   (b) Reversible memory impairments
   (c) Thought process impairment
      —impairment in abstract thinking
      —limitations in ability to conceptualize
      —periodic episodes of mental confusion.
5. Previous outpatient treatment has failed.
6. Multiple drug dependency.

OUTPATIENT TREATMENT

Admission to outpatient treatment depends on one or more of the following:

1. Patient does not fit criteria for detoxifcation, specifically, patient does not present acute withdrawal symptoms (refer to detoxification criteria).
2. Patient does not fit criteria for inpatient evaluation and rehabilitation program.
3. Patient has ability to remain sober for at least five days.
4. Patient is willing to take Antabuse if medically recommended.
5. Patient is willing to attend AA.
6. Patient is willing to have family involvement. ■

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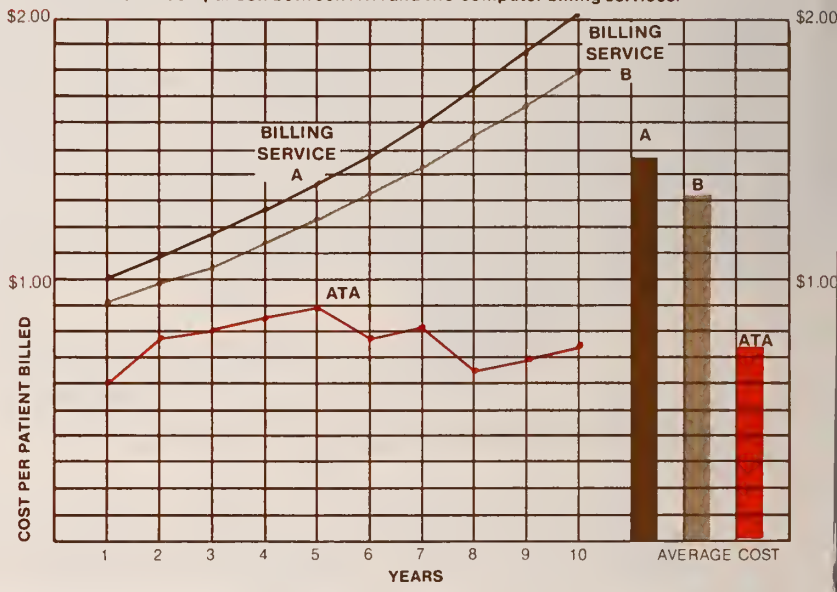

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GESIC—Abbreviated Summary

ICATIONS: Based on a review of this drug by the onal Academy of Sciences—National Research ncil and or other information FDA has classified ndications as follows

sibly effective for the treatment of pain accom- ed by tension and or anxiety in patients with mus- skeletal disease or tension headache

l classification of the less-than-effective indications ires further investigation

effectiveness of Equagesic in long-term use, i e e than four months, has not been assessed by sys- atic clinical studies The physician should periodi- reassess usefulness of the drug for the individual ent

RAINDICATIONS: Equagesic should not be given to uals with a history of sensitivity or severe intolerance in, meprobamate or ethoheptazine citrate

INGS: Careful supervision of dose and amounts pra- l for patients is advised especially with those patients own propensity for taking excessive quantities of drugs sive and prolonged use in susceptible persons, e g ics, former addicts, and other severe psychoneurot- s been reported to result in dependence on or habit- to the drug Where excessive dosage has continued eks or months, dosage should be reduced gradually than abruptly stopped, since withdrawal of a "crutch" reciprate withdrawal reaction of greater proportions al for which the drug was originally prescribed Abrupt inuance of doses in excess of the recommended dose sulted in some cases in the occurrence of epileptiform s

l care should be taken to warn patients taking mepro- that tolerance to alcohol may be lowered with result- ning of reaction time and impairment of judgment and ation

E IN PREGNANCY AND LACTATION: An increased congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug. Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentration in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness ataxia or visual disturbance occur, the dose should be reduced If symptoms continue patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma shock vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken sleep ensues rapidly and blood pressure pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow CNS stimulants e g caffeine Metrazol or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae ecchymoses, peripheral edema and fever have also been reported

More severe cases, observed only very rarely may also have other allergic responses, including fever, fainting spells angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case) thrombocytopenic purpura, agranulocytosis and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which if it occurs, usually requires whole blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

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for mild to moderate pain

Wygesic®IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

More than twice as much acetaminophen as the leading combination plus a full therapeutic dose of propoxyphene...all in a convenient, economical single tablet.

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
MANAGEMENT OF OVERDOSAGE: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill, however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity (jaundice, coagulation defects, hypoglycemia, encephalopathy, coma), and death may follow. Renal failure due to tubular necrosis and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists naloxone, nalorphine and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered preferably I.V., simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other sup[illegible] tive measures should be used as indicated. Ga[illegible] lavage may be helpful. Activated charcoal can [illegible] sorb a significant amount of ingested propoxyph[illegible] Dialysis is of little value in poisoning by prop[illegible] phene alone. Acetaminophen is rapidly absor[illegible] and efforts to remove the drug from the body sh[illegible] not be delayed. Copious gastric lavage and or in[illegible] tion of emesis may be indicated. Activated cha[illegible] is probably ineffective unless administered al[illegible] immediately after acetaminophen ingestion. Ne[illegible] forced diuresis nor hemodialysis appears to b[illegible] fective in removing acetaminophen. Since ace[illegible] nophen in overdose may have an antidiuretic e[illegible] and may produce renal damage, administratio[illegible] fluids should be carefully monitored to avoid [illegible] load. It has been reported that mercaptamine [illegible] teamine) or other thiol compounds may protect ag[illegible] liver damage if given soon after overdosage [illegible] hours). N-acetylcysteine is under investigation [illegible] less toxic alternative to mercaptamine, which [illegible] cause anorexia, nausea, vomiting, and drowsi[illegible] Appropriate literature should be consulted for fu[illegible] information. (JAMA 237:2406-2407, 1977).
Clinical and laboratory evidence of hepatotoxicity [illegible] be delayed up to one week. Acetaminophen pl[illegible] levels and half-life may be useful in assessin[illegible] likelihood of hepatotoxicity. Serial hepatic en[illegible] determinations are also recommended.

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Methods of diagnosis of acute adrenal hemorrhage complicating anticoagulant therapy—abdominal CAT scanning. . .

Douglas E Swift, MD; Edwin L Overholt, MD and **Renato Travelli, MD,** La Crosse, Wisconsin

ABSTRACT. *Three cases of acute adrenal hemorrhage following anticoagulation therapy are presented. There was no evidence of bleeding elsewhere and the prothrombin time and the partial thromboplastin time were in the therapeutic range. In two of these cases the diagnosis was made before death, in one because of an abnormal Cortrosyn test and in one because of a positive computerized axial tomographic (CAT) scan and cosyntropin (Cortrosyn) test. In two of the three reported cases the CAT scan was performed and was positive. This condition is less rare than thought (we had three cases in three years). The CAT scan can be a rapid and conclusive way to show enlargement of the adrenal glands secondary to adrenal hemorrhage.*

ACUTE BILATERAL adrenal hemorrhage with resultant adrenal insufficiency is a known complication of anticoagulation therapy. Approximately 60 cases have been reported in the medical literature. Since the initial report in 1947, only 11 of these 60 patients have had the diagnosis made ante mortem, been treated with steroids, and survived.[1]

Presented here are three cases of adrenal hemorrhage and insufficiency which have complicated anticoagulant therapy. In two the diagnosis was made ante mortem; they survived with the administration of corticosteroids. Although the incidence of acute adrenal hemorrhage secondary to anticoagulant therapy is unknown, it should be reemphasized that this complication is more common than most clinicians suspect.[2,3] The utility of the one-hour Cortrosyn stimulation test in establishing adrenal insufficiency and abdominal computerized axial tomographic (CAT) scanning confirming bilateral adrenal enlargement as a result of hemorrhage will be emphasized.

CASE REPORTS. *Patient 1.* A 56-year-old male was admitted to a local hospital in April 1976 with slurred speech and left upper extremity weakness. These neurological deficits cleared within 48 hours. Heparin, 5000 units USP, was administered intravenously every four hours for a presumed transient ischemic attack. The patient did well until 10 days after initiation of heparin therapy when he began to complain of severe subxiphoid pain that radiated to the left flank. Vital signs were stable. The patient was transferred to our institution for further evaluation. Electrocardiographic studies were suggestive of an inferior myocardial infarction, age undetermined. Intermittent intravenous heparin at 4000 units every four hours was continued.

On the 12th hospital day the patient complained of pain that started in the lower part of the chest and radiated to both flanks. There was increasing abdominal tenderness, and the hemoglobin level dropped 2 gm. Retroperitoneal hemorrhage was suspected. On the 14th hospital day tachycardia, hypotension, oliguria, a fever of 39.5 C prompted the initiation of chloramphenicol, gentamicin, and penicillin. All cultures obtained prior to antibiotic therapy were subsequently negative. A pulmonary catheter was placed, and dopamine, intravenous fluids, and furosemide (Lasix®) given intravenously reversed the hypotension and oliguria. However, a daily fever, epigastric and flank pain persisted. On the 16th hospital day serum sodium was 132 mEq/liter and the serum potassium was 5.3 mEq/liter. An abdominal CAT scan on the 20th hospital day disclosed a 5 cm mass anterior and superior to the left kidney. This was thought to represent a perinephric abscess. A repeat intravenous pyelogram was performed and was normal. On the 21st hospital day the serum sodium was 128 mEq/liter and serum potassium had increased to 5.9 mEq/liter. Exploratory surgery was scheduled but the patient's clinical status deteriorated, shock ensued, and the patient died that evening despite vigorous supportive therapy.

Postmortem examination disclosed destruction of both adrenal glands by hemorrhage, an old anterior myocardial infarction and several areas of old cerebral infarction. The left adrenal gland weighed 150 gm and the right adrenal gland weighed 50 gm. Subsequent review of the abdominal CAT scan revealed a mass anterior and medial to the upper pole of the

From the Gundersen Medical Foundation, Ltd, La Crosse, Wisconsin. Publication support provided. Reprint requests to: Edwin L Overholt, MD, Director of Medical Education, Gundersen Medical Foundation, Ltd, 1836 South Ave, La Crosse, Wisconsin 54601 (phone: 608/782-7300, ext 2281). Copyright 1981 by the State Medical Society of Wisconsin.

right kidney as well as the left (Fig 2). These masses represented the enlarged hemorrhagic adrenal glands. The patient died of undiagnosed acute adrenal insufficiency secondary to adrenal hemorrhage.

Patient 2. A 56-year-old male was admitted in April 1977 with two episodes of throat tightness accompanied by shortness of breath. An electrocardiographic study was consistent with an evolving acute posterior myocardial infarction. He developed a

FIGURE 1—*The normal adrenal glands are depicted as slit-like structures. The flat right adrenal gland lies posterior to the vena cava, whereas the left adrenal gland lies anteromedial to the upper pole of the left kidney. The normal adrenal glands (arrows) are inconspicuous on abdominal CAT scans.*

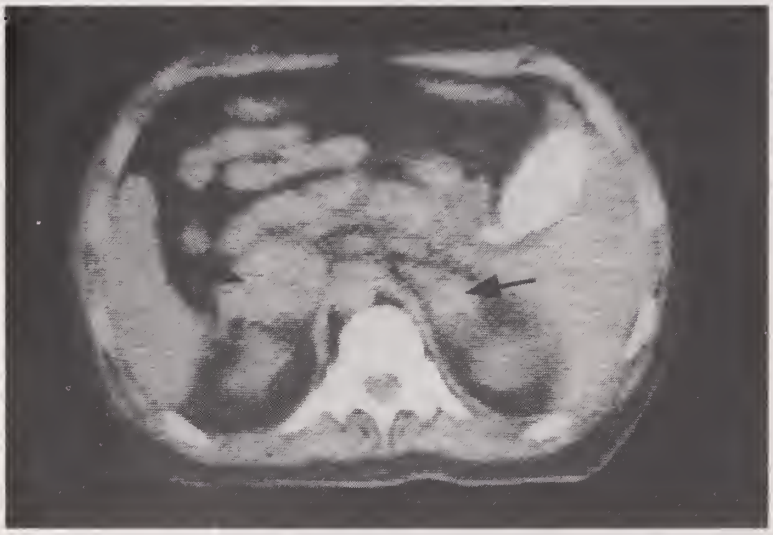

FIGURE 2—*Abdominal CAT scan obtained 10 days after adrenal hemorrhage in Patient 1. Both left and right adrenal glands are markedly enlarged (arrows). The left is larger than the right and is about 5 cm in diameter.*

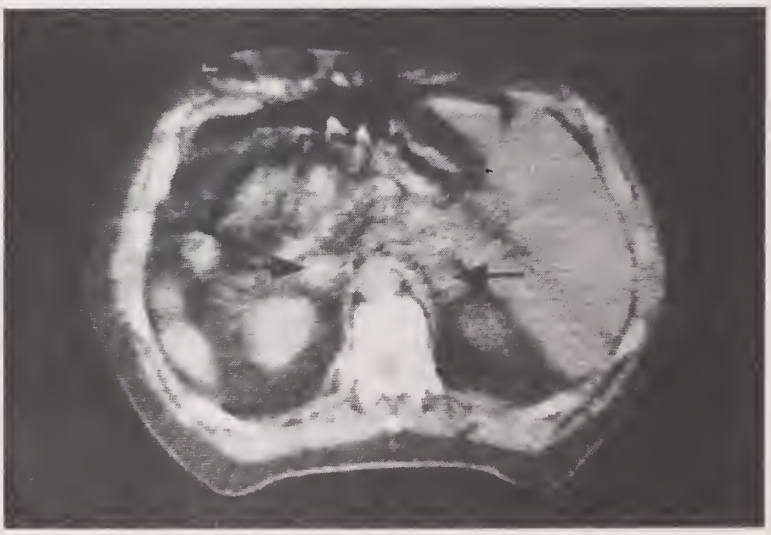

FIGURE 3—*Abdominal CAT scan obtained 13 days after adrenal hemorrhage in Patient 3. Both left and right adrenals are enlarged (arrows). They lie anterior and medial to the upper poles of the kidneys and have lost their normal slit-like shape.*

small infiltrate on chest x-ray film on the second hospital day and pulmonary embolism was thought responsible. Four thousand units of intravenous heparin every four hours was started. Oral warfarin was added on the fifth hospital day and the heparin was discontinued on the sixth hospital day.

The patient's recovery was uneventful until eight days after initiation of anticoagulant therapy when he complained of sudden right flank pain radiating through to the right upper quadrant. An intravenous pyelogram and oral cholecystogram were negative. The following day he developed a fever to 39 C and hypotension. The hematocrit was 41.8% and the white blood cell count was 11,200 cells per cu mm with a differential count of 68 polymorphonuclear leukocytes, 2 stab forms, 25 lymphocytes, 4 monocytes, and 1 eosinophil. Blood cultures were subsequently negative. On the 13th hospital day the patient developed atrial fibrillation with a rapid ventricular response and the hematocrit fell to 33.7%. Warfarin was discontinued and the anticoagulation was reversed with vitamin K. Pulmonary artery catheter pressures confirmed the presence of hypovolemia. Serum sodium was 125 mEq/liter and serum potassium was 4.6 mEq/liter. Despite hypovolemia and hyponatremia, the patient's urine sodium was 132 mEq/liter. These findings suggested adrenal insufficiency. Dexamethasone was given in a dose of 10 mg intravenously every six hours. The following morning a basal plasma cortisol was low at 1.9 mcg/100 ml. Two hundred fifty micrograms (1 amp) of cosyntropin (Cortrosyn) were given by intravenous bolus and one hour later a serum cortisol was 2.3 mcg/100 ml. The diagnosis of adrenal insufficiency secondary to bilateral adrenal hemorrhage was confirmed. Dexamethasone was discontinued and hydrocortisone was begun at 50 mg intravenously every four hours. His symptoms resolved rapidly. He was discharged on oral maintenance cortisone acetate 24 days after admission. Unfortunately, he had to be readmitted one month later with proven deep vein thrombophlebitis. During the course of treatment with heparin, he suffered an acute anterior myocardial infarction, arrested, and died. No postmortem examination was obtained.

Patient 3. A 66-year-old male was admitted in October 1978 with osteoarthritis involving the left hip. He underwent total hip replacement. His course was complicated by a urinary tract infection, sepsis, and deep vein thrombophlebitis. On the ninth hospital day heparin 5000 units intravenously every six hours was started. Warfarin was added several days later. Eight days after initiating heparin therapy he had an episode of sudden, severe epigastric abdominal pain which radiated toward the back. An electrocardiogram was unchanged. The pain resolved within 24 hours and heparin was discontinued. The patient was discharged the following day on an oral maintenance dose of warfarin.

He was readmitted five days later complaining of persistent weakness, fatigue, anxiety, and depression. The vital signs were stable and there was no fever. Physical examination was unremarkable. Initial laboratory studies included a white blood cell count of 8200 cells per cu mm with a differential count of 53 polymorphonuclear leukocytes, 7 band forms, 26 lymphocytes, 7 monocytes, 6 eosinophils, and 1 basophil. Serum sodium was 130 mEq/liter and serum potassium was 6.4 mEq/liter. A prothrombin time was 22.5 seconds with a control of 11 seconds. Adrenal insufficiency was suspected. A random plasma cortisol that evening was 8.0 mcg/100 ml. Two hundred fifty micrograms (1 amp) of Cortrosyn were then administered by intravenous bolus. One hour later a serum cortisol was 9.2 mcg/100 ml, confirming the diagnosis of adrenal insufficiency. The patient responded well to intravenous hydrocortisone and later to oral maintenance cortisone acetate. Prior to discharge, an abdominal CAT scan disclosed bilateral masses located anterior and medial to the upper poles of the kidneys (Fig 3). The masses were felt to be consistent with enlarged adrenal glands due to bilateral adrenal hemorrhage.

DISCUSSION. Three cases of bilateral hemorrhage occurring over three years at one institution indicate that this is not a rare complication. Hemorrhage occurs on an average of eight days after initiation of anticoagulant therapy, but has varied from 2 to 22 days in most reports.[4] McDonald did report one case of adrenal hemorrhage occurring 100 days after initiation of anticoagulants.[4] Otherwise, there have been no reports of this complication in patients maintained on long-term anticoagulation.

Excessive anticoagulant therapy apparently has not been responsible for the hemorrhage in Amador's study,[5] as clotting studies outside of the therapeutic range occurred transiently in only 50% of his patients. Others have suggested transient prolonged clotting times do play a role in the pathogenesis.[4] However, as in our three cases prothrombin times were in the therapeutic range and there was no evidence of bleeding elsewhere in the body. Adrenal hemorrhage has been reported in patients anticoagulated with either heparin or warfarin or both.[5]

Acute adrenal hemorrhage presents with pain. It is usually epigastric but flank, back and lower chest pain may occur. It can be confused with an acute surgical abdomen or an acute myocardial infarction. Additional symptoms include fever, confusion, lethargy, weakness, nausea, and vomiting. Hypotension and tachycardia develop and are manifestations of shock and impending death. The signs and symptoms of adrenal insufficiency often are incorrectly attributed to Gram-negative sepsis and shock.

There is an interval of days, weeks, or even months between the episode of acute adrenal hemorrhage and the development of adrenal insufficiency.

This varied between 3 and 40 days in McDonald's review,[4] but the average interval was only eight days. Because of this time interval between hemorrhage and adrenal insufficiency, the clinician may not diagnostically associate the two events.

Laboratory tests may be helpful in making the diagnosis. Hyponatremia and hyperkalemia are usually present.[4] A leukocytosis usually develops and a total eosinophil count greater than 50 cells per cu mm is highly suggestive of adrenal insufficiency in the acutely ill.[5]

The ante mortem diagnosis of acute adrenal hemorrhage has been the exception. A single random plasma cortisol does not establish adrenal insufficiency. The one-hour Cortrosyn stimulation test has proved an expedient way to confirm acute adrenal insufficiency. We wish to emphasize the use of CAT scan in demonstrating bilateral adrenal enlargement.

The normal adrenal glands appear as inconspicuous slit-like structures on abdominal CAT scan (Fig 1). In contrast, hemorrhagic glands lose their normal shape, become rounded and enlarged. They appear as distinct masses which lie anterior and medial to the upper poles of the kidneys. In both of our scans, obtained 10 and 13 days after acute abdominal pain and the presumed adrenal hemorrhage, the density of the enlarged adrenals was approximately the same as that of the kidneys.

The adrenal glands may not be involved equally and this will be reflected in findings on abdominal CAT scan. For instance, a large left adrenal gland of slightly increased density is visible on the scan of our first patient (Fig 2). A lesser adrenal enlargement is visible on the right. Autopsy confirmed hemorrhage was greater in the left adrenal gland. This gland weighed 150 gm while the right gland weighed 50 gm. The scan of our third patient suggests equal hemorrhage into both glands (Fig 3). The adrenal glands in this patient are considerably smaller than those seen in our first patient and suggest a lesser amount of hemorrhage.

With the current use of abdominal CAT scanning in difficult abdominal diagnostic problems, radiologists should be aware of the radiological presentation of bilateral adrenal hemorrhage. Even if the diagnosis is not suspected prior to obtaining the scan, it can be made if these bilateral masses are recognized as enlarged adrenal glands in a patient under stress in whom anticoagulants were recently initiated.

SUMMARY. Anticoagulant therapy complicated by bilateral adrenal hemorrhage in the hospital setting is not rare. A high index of suspicion in the appropriate clinical setting is essential. We have presented three cases occurring within the past three years. Upper abdominal or flank pain developed 8 to 10 days after the initiation of anticoagulant therapy and heralded the onset of adrenal hemorrhage. Varying features of adrenal insufficiency ensued. There was no evidence of bleeding elsewhere and the prothrombin time and partial thromboplastin time were within the therapeutic range. The first case described was presumed to have had a retroperitoneal hemorrhage or a perinephric abscess. CAT scan disclosed a suprarenal mass and an exploratory laparotomy was scheduled. Unexpectedly irreversible shock the evening before surgery precluded this approach. Subsequent to this experience the next two cases were recognized. Cortrosyn stimulation test confirmed the presence of adrenal insufficiency and a CAT scan disclosed adrenal enlargement due to hemorrhage.

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ABSTRACT

Ulcerative eosinophilic granuloma of the tongue; a light- and electron-microscopic study

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Ulcerative eosinophilic granuloma of the tongue simulates histiocytosis X or cancerous lesions, and may be subjected to unnecessary excessive treatment. This case report illustrates its benign, self-limited nature, discusses the differential diagnosis, and postulates its pathogenesis on the basis of light- and electron-microscopic findings. ■

CORRECTION: In the September 1981 issue there is an error in the article, "Computed tomography of the lumbar facet joints," by Boedecker, Kim, and Nix. On page 21 the illustrations are transposed, thus the illustration above Figure 1(b) is actually Figure 1(a) and the illustration above Figure 1(a) is actually Figure 1(b). The *Wisconsin Medical Journal* and its printer apologize for this error.

Two-dimensional echocardiographic detection of left atrial thrombi. . .

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ABSTRACT. *Two patients with mitral stenosis in whom unsuspected left atrial thrombi were detected by two-dimensional echocardiography (2DE) but not by M-mode echocardiography are presented as well as a third patient with mitral insufficiency. Although left atrial thrombus frequently complicates mitral valve disease, particularly mitral stenosis, reliable detection has been difficult. Two-dimensional echocardiography improves our ability to evaluate the left atrium by allowing spatially-oriented examination of the heart. Diagnosis of left atrial thrombus by 2DE will allow better planning of invasive diagnostic procedures.*

M-MODE AND two-dimensional echocardiography have proved useful in the diagnosis of intracardiac masses, particularly myxomas and vegetations.[1,2,3] Increasingly intracardiac thrombi are being identified with the use of wide-angle, two-dimensional echocardiography.[4,5,6]

Although thrombus formation in the left atrium is frequent in patients with mitral disease, reliable detection has proved difficult. A few reports of left atrial thrombi detected by M-mode echocardiography are available.[7,8,9,10] A preliminary report noted two patients with left atrial thrombi found by two-dimensional echocardiography (2DE) but the underlying diseases were not stated.[5] The same investigators have also reported that massive left atrial thrombi can be readily diagnosed by 2DE in patients with mitral stenosis.[6] Others have described three patients with prosthetic mitral valves in whom left atrial thrombi were demonstrated by 2DE but not by M-mode studies.[11]

In this paper we present two patients with mitral stenosis and one with mitral insufficiency who were found by 2DE to have a left atrial thrombus in an unexpected location after M-mode echocardiography was not diagnostic. We discuss the advantages of this technique over previously available methods for the evaluation of the left atrium.

METHODS. In two patients M-mode and two-dimensional echocardiography was done using a Toshiba model SSH-10A echocardiograph with strip chart recorder and NEC videocassette recorder. In the other patient the studies were obtained with the Smith-Kline Ekoline 20 echocardiograph with Ekoline 21 strip chart recorder and VTC 7100 video tape recorder. The M-mode echocardiograms were done by placing the transducer in the fourth intercostal space at the left sternal border. Two-dimensional images were obtained in the long-axis and short-axis views from the same location. An apical four-chamber view was obtained by placing the transducer at the cardiac apex and directing the ultrasound beam to image the four heart chambers.

CASE REPORTS. *Case 1.* A 54-year-old woman was evaluated for orthopnea and paroxysmal nocturnal dyspnea. She had jugular venous distention and two-plus pretibial edema. Râles were heard at both lung bases. An irregularly irregular rhythm was present, along with an increased first heart sound, and a grade 3/6 rumbling diastolic murmur. No opening snap was heard. The electrocardiogram showed atrial fibrillation. The chest x-ray film showed cardiomegaly and pulmonary vascular redistribution. M-mode echocardiography confirmed mitral stenosis with left atrial enlargement (55 mm); no abnormal echoes were seen in the left atrium (Fig 1a). Two-dimensional echocardiography revealed an immobile mass in the left atrium located adjacent to the interatrial septum on short-axis view (Fig 1b). Cardiac catheterization demonstrated severe mitral stenosis without mitral regurgitation (calculated mitral valve area 0.5 cm^2). At surgery a 2.5 x 2 x 1 cm thrombus was found in the identical location described by 2DE. The calcified, stenotic mitral valve was replaced with a No. 27 Bjork-Shiley prosthesis and the clot was removed. Pathologic examination showed a mixture of fibrinous material, red blood cells, and inflammatory cells; no neoplastic cells were present.

Case 2. A 67-year-old woman presented with progressive fatigue and exertional dyspnea. She had done well following a closed mitral valvulotomy 20 years previously for mitral stenosis and had a permanent pacemaker implanted nine years previously for atrial fibrillation with a slow ventricular rate. Physical examination revealed no jugular venous distention and clear lung fields. She had an increased first heart sound and an opening snap followed by a grade 3/6 rumbling diastolic murmur. The electrocardiogram showed a paced rhythm. Chest x-ray film showed cardiomegaly. The M-mode echocardiogram confirmed mitral stenosis with left atrial enlargement (58 mm); abnormal echoes were recorded intermittently in the left atrium (Fig

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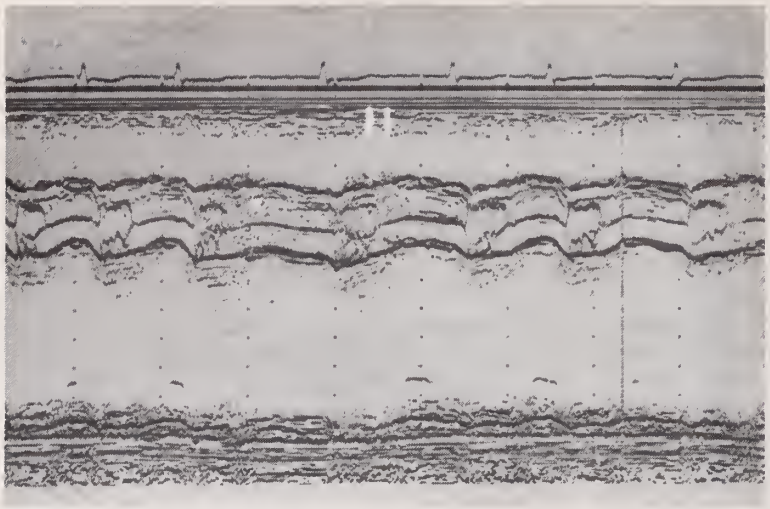

FIGURE 1a—*M-mode echocardiogram of Patient 1 showing left atrial enlargement but no abnormal left atrial echoes.*

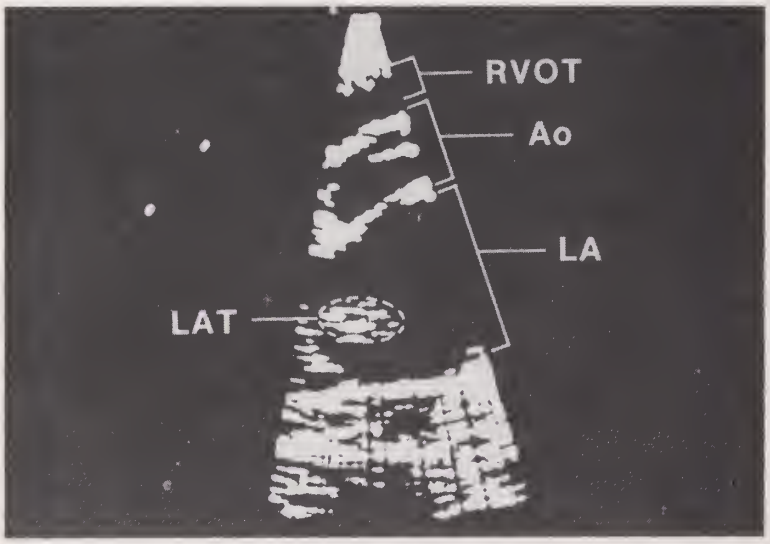

FIGURE 1b—*Short-axis view in which the thrombus is seen adjacent to the interatrial septum.*

See next page for KEY

2a). Two-dimensional echocardiography showed an immobile left atrial mass adjacent to the interatrial septum in the short-axis view (Fig 2b). Cardiac catheterization demonstrated moderately severe mitral stenosis and moderate mitral regurgitation (calculated mitral valve area 1.2 cm^2). At operation a 3 x 2 x 1 cm thrombus was found in the left atrium attached to the interatrial septum. The mitral valve was replaced with a No. 29 Bjork-Shiley prosthesis and the thrombus was removed. Pathologic examination showed a mixture of fibrinous material, red blood cells, and foci of calcification; no neoplastic cells were seen.

Case 3. A 56-year-old male with a history of ischemic cardiomyopathy presented with dyspnea. Physical examination revealed a loud S3 gallop and a holosystolic murmur at the apex. M-mode study showed left ventricular enlargement, left atrial dilatation, and hypokinetic wall motion. A 2DE revealed a mass attached to the left atrial appendage, presumably a thrombus (Fig 3). He was started on diuretics and anticoagulation.

DISCUSSION. Left atrial thrombus formation is frequent in mitral valve disease, particularly mitral stenosis. In a large autopsy series from the presurgical era, 27% of patients with rheumatic heart disease had intracardiac thrombi; although it was not explicitly stated, most were presumably in the left atrium.[12] In a report of early surgical experience with open mitral commissurotomy, 22% of patients had atrial thrombi.[13] Despite the high incidence of left atrial thrombi found at autopsy or operation, diagnosis by available clinical methods has been difficult and unreliable.

A history of systemic embolization does not predict the presence of left atrial thrombus nor does the lack of embolization preclude finding thrombus.[13] Pulmonary angiography has demonstrated left atrial thrombi in approximately 10% of patients with mitral stenosis and atrial fibrillation and correlated well with surgical findings.[14] However, pulmonary angiography requires an additional bolus of contrast material, which may not be tolerated well by patients with pulmonary hypertension and which may

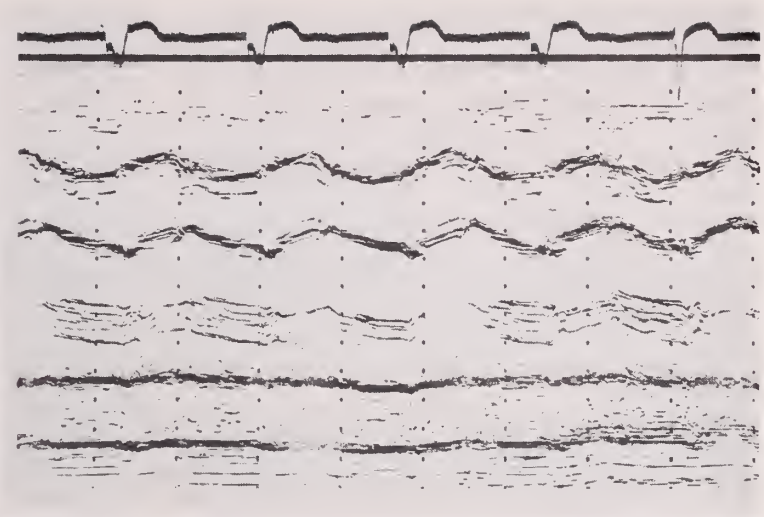

FIGURE 2a—*M-mode shows evidence of left atrial enlargement with some abnormal echoes within the left atrium.*

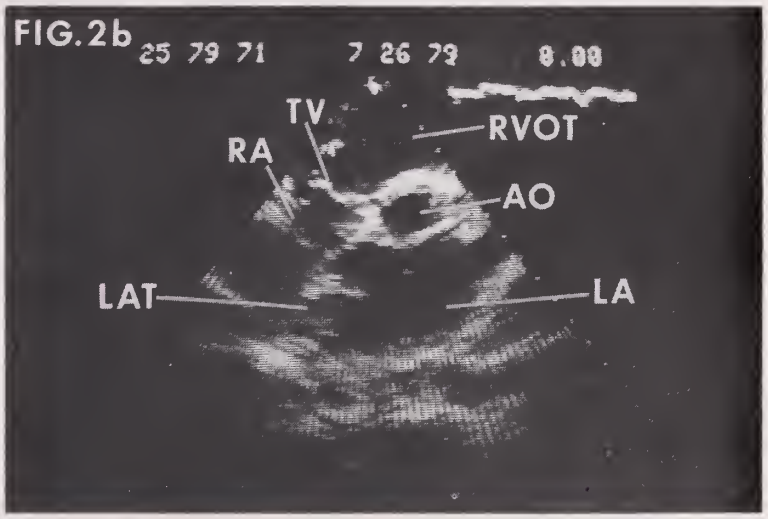

FIGURE 2b—*Short-axis view in which the thrombus is seen adjacent to the interatrial septum.*

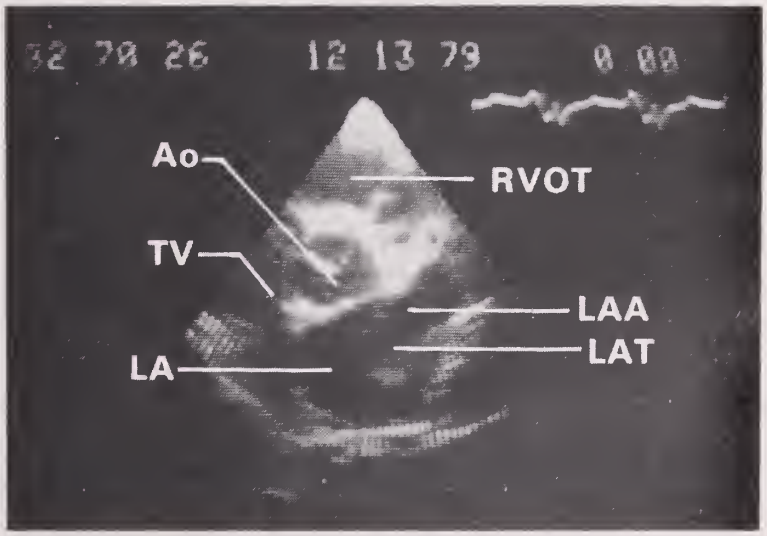

FIGURE 3—*Short axis view in which the thrombus is seen attached to the left atrial appendage.*

KEY:

Ao = aorta; IAS = interatrial septum; IVS = interventricular septum; LA = left atrium; LAA = left atrial appendage; LAT = left atrial thrombus; LV = left ventricle; MV = mitral valve; RA = right atrium; RV = right ventricle; RVOT = right ventricular outflow tract; TV = tricuspid valve.

poorly opacify the left atrium in patients with high pulmonary vascular resistance and low cardiac output. Transseptal left atrial angiography may demonstrate thrombi,[15] but in addition to the well-recognized risks of this procedure,[16] transseptal puncture has the potential of dislodging all or part of a thrombus because of needle and catheter insertion into the left atrium.

ECHOCARDIOGRAPHY. M-mode echocardiography has not added substantially to the preoperative diag-

nosis of left atrial thrombus despite its value in the detection of prolapsing left atrial myxoma. Since the thrombus doesn't move and M-mode largely depends on motion to identify structures, it is not surprising that the M-mode has not been reliable in detecting left atrial thrombi. The left atrial appendage, traditionally accepted as a common site of thrombus formation, is not commonly imaged. Although the body of the left atrium is the site of thrombus formation as frequently as the appendage,[17] it may not be completely examined by M-mode echocardiography because of the narrow ultrasound beam and the difficulty appreciating spatial orientation.

Echoes recorded in the left atrium may not be diagnostic of a mass lesion. Unexplained echoes are often recorded and abnormal echoes may result from a large coronary sinus or abnormal pulmonary veins.[1] Improper gain setting may result in abnormal echoes in the left atrium originating from reverberation from sclerotic aortic root. When the transducer is not positioned properly, nondiagnostic echoes in the left atrium may originate from a calcified mitral valve annulus. Disappearance of echoes within the left atrium following mitral valve surgery and removal of a left atrial thrombus is convincing evidence that the thrombus caused the echoes,[8] but preoperative M-mode echocardiograms alone are not diagnostic and do not predict size and location. In addition, "false-positive" reports of left atrial thrombus may be made using M-mode tracings.[7]

Two-dimensional echocardiography allows better interrogation of the heart than does M-mode echocardiography. Distinct spatial and anatomic relationships are displayed and can be viewed in multiple tomographic planes. Its advantage in detecting and detailing intracardiac abnormalities is well illustrated by the findings in the two patients presented here. In neither patient did the M-mode echocardiogram define an atrial mass although in one patient nonspecific echoes in the left atrium raised the possibility. Two-dimensional echocardiography clearly defined the left atrial mass in each patient, including size, shape, margins, and location. The short-axis and apical four-chamber views furnished excellent definition of each mass, but the long-axis view failed to detect it in either patient despite scanning in several planes. Because the masses were immobile their detection depended on thorough scanning with the ultrasound beam transsecting many planes of the heart. The left atrial appendage is best visualized in the parasternal short axis view angulating the transducer posteriorly and superiorly up from the mitral valve behind the pulmonary outflow tract. The short axis parasternal view at the aortic level appears to be the best position to visualize the atrial appendage. The left atrial appendage is very difficult to evaluate even with two-dimensional echocardiogram because of its lateral position and refractile echoes surrounding the appendage.

Awareness of a thrombus in the left atrium is important when considering the technique of cardiac catheterization in patients with mitral stenosis. Specifically, transseptal puncture may be considered to obtain left atrial and left ventricular pressures and to do contrast angiography. In the presence of a left atrial thrombus, particularly when it is located adjacent to the interatrial septum, the risk of dislodging a portion and producing systemic embolization is considerable. In addition, a thorough two-dimensional study obviates pulmonary angiography to evaluate the left atrium for size and presence of thrombus. The presence of thrombi in the atrium documented by two-dimensional echocardiogram would make one consider an open mitral commissurotomy instead of a closed procedure due to the risk of embolization. The absence of a tumor stalk or motion distinguish a thrombus from proplapsing myxoma.

By permitting examination of the heart in multiple planes with a wide-angle ultrasound beam, two-dimensional echocardiography is superior to M-mode echocardiography for complete evaluation of the left atrium in patients with mitral stenosis. When done by a skilled echocardiographer, it may detect unsuspected thrombi and eliminate consideration of additional procedures. Its sensitivity in detecting small left atrial thrombi is unknown but as additional patients are studied, we expect this to be clarified.

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A comparative study of techniques for esophageal foreign body removal with special emphasis on meat bolus obstruction. . .

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ABSTRACT. *Ninety-seven patients with retained foreign objects of the esophagus were endoscopically evaluated during a five-year period from January 1976 to December 1980. Fifty-five (57%) were meat boluses, 24 (25%) metallic objects, and 7 (7%) were bones. Rigid and flexible endoscopes were comparatively safe and effective in the removal of metallics and bones. Rigid endoscopes continue to be the apparent choice for children with upper esophageal objects. Meat bolus obstructions were removed successfully with other techniques, but the flexible technique was safer (0% complication compared to 16% with rigid scope). Rigid endoscopic removal of meat bolus was 2.7 times as expensive. Meat bolus in the distal esophagus in adults should be removed by flexible techniques if unrelieved by noninvasive means. Blind forceful dilatation is dangerous.*

In 1904 Einhorn removed two esophageal foreign bodies through the use of a rigid esophagoscope.[1] This technique continues to be the principal method of removal for the estimated 10% to 20% of ingested foreign bodies that do not pass spontaneously.[2] Flexible endoscopic removal of esophageal foreign objects of various types has been reported with increasing frequency.

Although the projected complication rate for flexible endoscopic removal is 1.3 per 1000 cases, no complications have been reported.[3] Rigid esophagoscopic removal of foreign bodies has a reported complication rate of 1% to 2%.

The flexible procedure is performed on outpatients under sedation, while the rigid instrumentation usually requires hospitalization and general anesthesia. The purpose of this article is to compare the two procedures in the removal of esophageal foreign bodies with special emphasis on meat bolus obstruction. The comparison includes patient population, foreign body type and location, success rate, complication rate, and the cost of each procedure. With the aid of published reports, guidelines for the proper patient selection for each procedure will be outlined.

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METHODS. All inpatient and outpatient records of patients undergoing esophageal foreign body removal from January 1976 to December 1980 were reviewed by retrospective analysis. St Luke's Hospital and St Mary's Medical Center (Racine, Wisconsin) serve an estimated referral population of 150,000. Both hospitals are well equipped for rigid and flexible endoscopy. All consultants used both hospitals. The physicians performing the techniques were all well trained and experienced specialists. They included thoracic surgeons (2), otolaryngologists (2), and gastroenterologists (4). The thoracic surgeons and otolaryngologists used rigid endoscopes under general anesthesia. The gastroenterologists used flexible endoscopes under topical anesthesia and sedation.

Data recorded included patient's age and sex, foreign body type and location, length of anesthesia, underlying pathology, length of hospital stay (LOS), success rate, complication rate, and cost.

GENERAL RESULTS. Ninety-seven cases of retained esophageal foreign bodies were evaluated from 1976 through 1980. Meat bolus obstruction occurred in 55 of 97 (57%) of foreign bodies of the esophagus. Metallic foreign bodies accounted for 24 of 97 (25%). Coins were the majority of metallics—16 of 24 (67%). Fourteen of 16 coins were removed by rigid endoscopy. The age range was 1 year to 23 years (average age—3.2 years). The average length of stay was 1.1 days. The average total cost of rigid endoscopic removal was $804. The average total cost for flexible endoscopic removal for outpatients was $417. Rigid esophagoscopic extraction was 1.9 times as costly. There were no complications with either flexible or rigid procedures. All metallic foreign bodies were successfully removed. Bones accounted for 7 of 97 (7%) of esophageal foreign objects. Five were removed by the rigid endoscopic method and two by the flexible endoscope. No complications occurred in either group and all were successful.

The upper esophagus (the hypopharynx to 20 cm) harbored 37% of all objects. The mid-esophagus

Table 1—Esophageal meat bolus obstruction 1976-1980

	Rigid endoscopy	Flexible endoscopy
Patients	25	30
No foreign bodies seen	2	0
Successful	22	28
Removed	18	9
Advanced	4	19
Underlying pathology Identified	2	15
Complications	4	0
Penumonia	2	
Bleeding	1	
Perforation	1	
Average cost per procedure	$1172	$440

(20-30 cm) accounted for 19%. The distal esophagus (30 cm to the gastric esophageal junction) had 44% of all swallowed foreign bodies. Seventy-three percent of the metallic foreign bodies and 80% of bones were lodged in the upper esophagus.

MEAT BOLUS OBSTRUCTION. Table 1 summarizes the comparison of success rate, complication rate, and costs of the two procedures in meat bolus removal. Meat boluses were found in the upper esophagus in 9 of 53 (17%), in the mid-esophagus in 12 of 53 (23%), and in the distal esophagus in 32 of 53 (60%). No foreign body was found at endoscopy in two patients.

Thoracic surgeons performed 18, otolaryngologists 7, and gastroenterologists 4 of the 29 inpatient endoscopic removals of esophageal meat bolus obstructions. Gastroenterologists performed all of the 26 outpatient procedures using the flexible endoscopic technique. Meat boluses obstructed the esophagus of 16 female patients and 39 male patients. The age range was from 7 to 88 years. The average age was 59 years.

The average hospitalization for the patients undergoing rigid endoscopy for meat bolus removal was 4.5 days. Two patients accounted for 65 hospital days. One patient was admitted because of a cerebrovascular accident and developed a meat bolus obstruction on the fifth day. The meat bolus removal did not prolong the hospital stay. The second patient developed an esophageal perforation which resulted in a LOS of 52 days. Excluding these patients, the average LOS for rigid endoscopic removal of meat boluses was 2.8 days. The average length of anesthesia was 38 minutes. Aspiration pneumonia complicated one anesthetic induction. Rigid endoscopy removed meat boluses in 18 of 23 (78%) while in four patients (17%) Maloney dilators were used to force the boluses into the stomach.

The complication rate for rigid endoscopic meat bolus foreign body removal was 4 of 25 patients (16%). Aspiration pneumonia occurred in two patients. Two patients had esophageal tears. One of the patients bled requiring four units of blood, but he did not require surgery. The other had a distal esophageal perforation which required surgery, total parenteral nutrition, and a 52-day hospitalization. These two complications were induced by blind, forceful attempts by Maloney dilators to push the bolus into the stomach.

Underlying pathology was recorded in only 2 of 25 (8%) of patients who underwent rigid instrumentation.

The flexible endoscopic removal of meat boluses was successful in 28 of 30 (93%). No complications occurred in this group. In two patients rigid endoscopy was subsequently required. Underlying esophageal pathology was identified in 15 of 30 cases (50%). Hiatal hernia alone accounted for six cases and hiatal hernia with lower esophageal ring was found in five patients.

Cost analysis of the rigid and flexible techniques was adjusted for rate increases in the five-year period. Actual inpatient hospital bills were reviewed as well as professional fees for anesthesiologists and operators. Rigid endoscopic removal of meat boluses was 2.7 times as costly as flexible instrumentation.

DISCUSSION. The type and location of the esophageal foreign bodies is age and diet dependent. The results of this study confirm Baraka's report that children swallow metallic objects and these tend to lodge in the upper esophagus. Meat boluses obstruct the lower esophagus in the older patients.[3] Nandi reviewed 2394 cases treated in Hong Kong where the primary diet is fish and fowl. Eighty-four percent of all foreign bodies occurring in both adults and children were located in the upper esophagus. The difference between the current report and the Hong Kong study was the type of foreign object obstruction. In the current study meat accounted for 57% and bones 7%, while in Nandi's review bones accounted for 60% of the obstructions.[4]

The choice of rigid or flexible instruments for removal of foreign bodies of the esophagus is subject to author bias. The rigid endoscopic removal is recommended as the sole procedure by surgeons and otolaryngologists.[3,4,5] The development of flexible endoscopes and modification of retrieval equipment has resulted in the recommendation that the flexible instruments should be the first instrument used in removal attempts of all types of foreign bodies in any location.[6] The limits of the standard flexible endoscopic retrieval equipment is pointed out by Waye and Tedesco.[7,8] Newer techniques for foreign body retrieval by the flexible method have added to the versatility of the technique.[9,10,11]

There are no comparative series of esophageal foreign body removal techniques. In the present study in a community hospital setting, no attempts were made to modify referral patterns that would bias procedure selection. The primary care physicians tended to refer the younger patients with metallic foreign bodies of the upper esophagus to surgical subspecialists for rigid endoscopy under general anesthesia. Despite data suggesting flexible instruments be used under general anesthesia in children with metallic foreign bodies,[12] the lack of complications, short hospital stay, and comparable costs does not suggest modification of the existing referral patterns.

MEAT BOLUS OBSTRUCTION. Various techniques for non-endoscopic removal of meat boluses have been advocated. A solution of two teaspoons of meat tenderizer, papain, in 240 ml of water, is sipped in 20 ml doses over 90 minutes and has been suggested as an alternative approach. Cava reviewed its use in 90 reported cases and found two cases of death from perforation. The incidence of 3% perforation is higher than the reported 1% perforation rate for esophagoscopy.[13]

The risk of perforation from papain increases if the object has been present for greater than 24 hours. Pressure necrosis and ischemia accelerate the tissue injury by the enzymatic reaction. Papain was not used in the present series and is not recommended.[5,14]

A Foley catheter filled with contrast material can be passed into the nose and moved distal to the meat bolus obstruction. The balloon is filled with contrast and the catheter is withdrawn under fluoroscopy. The extracted object is removed from the mouth. The advantages are the lack of need for anesthesia, sedation, or more costly endoscopy.[15,16] Nixon reported that this technique was successful in 21 of 25 patients. Twenty of 25 were non-opaque and most were meat boluses. Eleven patients had underlying esophageal pathology. Sixteen of 21 were removed, three were advanced into the stomach, and two patients vomited the dislodged object. There were no complications.[16] However, the potential for perforation by the presence of other non-opaque sharp objects not visualized in the catheter technique is a definite disadvantage.[12]

Glucagon is reported to reduce the lower esophageal sphincter pressure without altering peristalsis.[17] Ferucci was the first to describe the use of glucagon in meat bolus obstruction.[18] The secretions are removed by a nasogastric tube and meglucamine diatrizoate is injected into the tube to localize the obstruction. One milligram of glucagon is administered intravenously. The bolus is observed under fluoroscopy. A second injection of 2 mg of glucagon is given if the bolus has not advanced into the stomach within 20 minutes. This technique was successful in 50% of cases without major complications.[14,17,18] This technique was used infrequently in the present series, but published reports definitely indicate it should be attempted. If the bolus fails to pass, then endoscopy is required.

The choice of flexible or rigid endoscopy to remove the remaining meat boluses is subject to author preference and not to available data. In the present series 28 of 30 patients with meat bolus obstructions were successfully relieved by flexible endoscopic techniques. Rigid endoscopy was used in 25 patients and required in the two patients in which flexible techniques failed.

The meat bolus removal by the flexible instrument frequently contradicts the dictum of not advancing the bolus into the stomach.[5] In the current series the bolus size was reduced by teasing apart the meat fibers and under direct vision extracting the bolus when possible. A technique of teasing and advancing the bolus into the stomach under direct vision was used in 68% of patients without complication, but 2 of 30 (7%) were unsuccessfully removed or advanced because of bolus size.

The rigid scope was unsuccessful in removal of a meat bolus in 4 of 23 (16%). In this group blind forceful advancement of the bolus by a Maloney dilator resulted in two major complications. The key difference is the lack of direct visual control. This supports the concept of avoiding blind forcing of a meat bolus into the stomach.

CONCLUSION. Using the above literature review and experience gained by the present series, it is recommended that non-opaque suspected meat bolus obstructions be localized by the glucagon nasogastric tube technique of Ferucci. Flexible endoscopic removal is the next step and, when unsuccessful, a rigid instrument should be used. If this technique is unsuccessful, surgery should be contem-

Table 2—The projected cost reduction—using the proposed glucagon—flexible endoscopic technique

Procedure	*Number*	*Average cost per procedure*	*Cost*
ACTUAL COST			
Flexible	30	$ 440.00	$13,200.00
Rigid	26	1,172.00	29,300.00
		Total	$42,500.00
PROJECTED COST			
Glucagon	55	$ 100.00	$ 5,500.00
Flexible	26	440.00	11,440.00
Rigid	2	1,172.00	2,344.00
		Total	$19,284.00

Projected savings $23,216.00 — a 55% reduction

plated before the use of blind forceful advancement with esophageal dilators. If the above approach had been used in the 55 cases of meat bolus obstruction, there would have been a cost reduction (Table 2). The glucagon technique, if successful in 50% of attempts, would have reduced the need for endoscopy to 26 patients. The success rate of flexible endoscopic removal of meat bolus was 93% and would have, therefore, required two patients to have undergone subsequent rigid endoscopy. Using the costs based on the current study, there would have been a 55% cost reduction (Table 2).

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MEDICAL BRIEF

Tumor angiogenesis factor with possible implications for glioblastoma multiforme

Bahij S Salibi, MD, Marshfield, Wisconsin

SINCE FOLKMAN'S[1] comprehensive review on the subject in 1976, a number of important landmarks have been attained:

1. The tumor angiogenesis factor has been sufficiently purified to induce longterm tissue cultures of cloned capillary endothelial cells,[2] and indeed to form a tubular capillary network *in vitro.*[3]

2. A quantitative *in vitro* assay for endothelial cell migration[4] can now be used to measure the concentration of the tumor angiogenesis factor in a tumor-conditioned medium.

3. The angiogenesis inhibitor, isolated from bovine cartilage[5] is now sufficiently purified to control tumor growth in the rabbit's eye by ipsilateral carotid perfusion; and the inhibition of tumor growth correlates well with the simultaneous inhibition of tumor angiogenetic activity.[6]

Prior to the above landmarks, a histologic angiogenetic grading system for the cerebral astrocytoma-glioblastoma spectrum had been developed,[7] demonstrating the close correlation of tumor angiogenetic activity with the Kernohan grading of malignancy and with postoperative patient survival.

Efforts are still in progress towards the development of "antiangiogenesis" as a therapeutic method for holding the postoperative remnants of glioblastoma in a stable, nonvascularized, harmless state. This may be accomplished by further purification of the angiogenesis inhibitor derived from cartilage, for establishment of its effectiveness and safety for oral or parenteral use in the human; or by the development of active or passive immunization against the tumor angiogenesis factor itself, after its purification and identification have been sufficiently established.

Presented at the joint meeting of the Wisconsin Neurological Society and The Minnesota Society of Neurological Sciences, Telemark Lodge, Cable, WI 54821, February 14 and 15, 1981. Doctor Salibi is a Neurosurgeon, Marshfield Clinic and Marshfield Medical Foundation, Inc, Marshfield, WI 54449, and Associate Clinical Professor, Neurological Surgery, University of Wisconsin Medical School, Madison, WI 53701.

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Look what SMS Services is doing for you

The SMS Services, Inc Board of Directors took the following actions in September that could directly affect physician members of the State Medical Society. The Board:

• Approved the following 1982 tour schedule: January—Tahiti (includes CME credits); March—Hawaii Cruise; July-August—Central Europe.

• Reported that a 40 percent discount rate has been negotiated with Avis for car rental.

• Approved offering a Purchase Power Program to all members outside Milwaukee County (those members already have the program through the county society) for $2.50 a year.

• Reported that the endorsed Group Term Life Insurance Program underwritten by Sentry Insurance will be ready for announcement in October. (See advertisement elsewhere in this issue.)

• Endorsed a new insurance program tailored for the medical profession called Retired Lives Reserve (RLR). Under this program service corporations can fund after retirement term-life premiums and consider them as tax-deductible expenses. Physicians should not take any action until they receive further information from SMS Services, Inc.

• Reported that the insurance agency activity is well under way to becoming a full-time agency to serve all the needs of members and others.

• Reelected the following officers: President-William P Crowley Jr, MD; Vice President-John P Mullooly, MD; Secretary-Earl R Thayer; Treasurer-Richard W Edwards, MD. ■

1982 Dues statements in the mail

The SMS Membership Department reports that 1982 dues statements have been mailed to all Society members. This year, in light of the House of Delegates' new membership policy, the statements contain the required dues for state and county membership, recommended but optional dues for the American Medical Association, as well as some voluntary contributions. Early payment is encouraged. ■

A brief description of SMS membership classifications

Are you a member of the State Medical Society of Wisconsin, or do you know someone who isn't? Whether you're just starting medical school, maintain a full-time practice, or are retired, SMS has a membership classification to fit your individual needs. Here is a brief description of membership classifications:

Regular—Member in active practice.

Part-time Practice—Physician who practices 1000 hours or less.

Resident—Member who is in an approved training program.

Associate—Member whose dues are waived because of illness or financial hardship.

Retired—Completely retired from practice.

Over Age 70—Member in active practice who is over 70 years of age.

Candidate—Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

If you'd like more information on these classifications and their corresponding dues, contact the SMS Membership Dept. ■

Nursing homes salute SMS President-elect

SMS President-elect Gerald C Kempthorne, MD, Spring Green, was named "Physician of the Year" September 22 by the Wisconsin Association of Nursing Homes. Doctor Kempthorne received the honor in recognition of his contribution to the care of the elderly in nursing homes and leadership in the field of geriatrics. Presently, he is the attending physician for residents in three Southern Wisconsin nursing homes: Maplewood of Sauk Prairie, Greenway Manor in Spring Green, and Black Earth Manor. The award to Doctor Kempthorne noted that he deserved the honor because "he has been a community leader for many years and also because he is a very caring and dedicated physician." ■

President-elect Kempthorne receiving the "Physician of the Year" award from Robert Gregory, president of the Wisconsin Association of Nursing Homes and administrator of Area Nursing Home, Colfax.

Physicians, others gather to discuss MD impairment problem

"While progress has been made in reaching those physicians who have alcohol, other drug, emotional or physical problems, it is my candid opinion that we have not reached those individuals in real need," SMS President-elect Gerald Kempthorne, MD told 75 physicians, hospital administrators, and clinic managers October 14 at a conference dealing with physician impairment.

The two-day program, which received high marks from those in attendance, was sponsored by the Coordinating Council on Physician Impairment of SMS and the State Medical Examining Board.

"Anyone in this room who knows of a physician compromised by an impairment has a moral obligation to his own self to help that doctor," Doctor Kempthorne said. "Conspiracy of silence is a disloyalty—not a virtue."

During the meeting, the SMS president-elect also announced that, in an effort to expand its Impaired Physician Program, the State Medical Society was currently developing plans to undertake a joint program with a treatment facility in Wisconsin to present regional

Gerald C Kempthorne, MD

Richard H Strassburger, MD

Clifford J. Simske, MD

Harry F Weisberg, MD; Betty Jo Maly, MD; and Willard M Duff, PhD

Ervin Teplin, MD; Betty Jo Maly, MD; and Joanna H Spiro, MD

Albert A Fisk, MD and Barry Blackwell, MD

Walter L Washburn, MD; H B Maroney; Richard H Strassburger, MD; and Gerald C Kempthorne, MD

Staff photos by Diane Upton

Rudolf W Link, MD; Daniel Kane, DPH; and Charles W Landis, MD

educational outreach, prevention, and intervention programs to physicians throughout the state.

Charles W Landis, MD, president of the Medical Society of Milwaukee County, agreed with Doctor Kempthorne's assessment and said that in Milwaukee County too few physicians take that extra step to offer an impaired colleague specific help in obtaining immediate evaluation and treatment. "True kindness," he said, "lies in bringing the illness behind impairment into treatment—not in efforts to conceal or abandon our brethren."

In a session dealing with prevention—stress points, Ervin Teplin, MD, Milwaukee, Clinical Professor, Dept of Psychiatry, Medical College of Wisconsin, stated that the very qualities that supported a physician's success in medical school and later in practice, become "burdensome, counterproductive and anxiety-producing."

Doctor Teplin said that physicians must recognize that the burnout syndrome is widespread among the profession. He advocated the use of peer support groups among medical students, residents, faculty, and practicing physicians as a means of helping impairment problems early.

Joanna H Spiro, EdD, Assistant Professor of Psychiatry at MCW, said the medical college had developed a peer counseling program for medical students. "We believe it is important for physicians to learn that they are not infallible, and that it is just as acceptable for them to need help and to seek counseling as any of the patients whom they see in the course of practice," she said.

Speaking on Physician Lifestyle and Medical Marriages, Barry Blackwell, MD, Chief of the Dept of Psychiatry at Mt Sinai Medical Center in Milwaukee, said most physicians enter medical school with a basic wish to care for others, but the end result is a professional role that is shaped by personal, peer and public expectations. "In short," he said, "we expect physicians to be omnipotent, omniscient, and omnipresent."

"In the end, physician marriages break down in the same areas as others, controversies over control, errors in communication, and unmatched needs for comfort and nurturance. But the personality profiles of the participants and the lifestyle of the physician make a considerable contribution," Doctor Blackwell said.

The afternoon program on Wednesday, October 14, featured presentations on the roles of professional peers and the hospital staff, the psychiatrist, the hospital administrator, the State Medical Society, the county medical society, and the Medical Examining Board in intervention and confrontation of the impaired physician.

Medical Examining Board member Gwen Jackson of Milwaukee pointed out that the Board makes every attempt to work with the physician who makes an effort to solve his/her problem and recapture their professional integrity, but that the physician must seek rehabilitation as soon as a problem exists and before the public suffers some harm because of an impairment.

"It is a known factor that very few physicians report a physician that they know to be impaired," Jackson said. "The fact remains, however, that the American Medical Association has repeatedly emphasized that it is an ethical responsibility for members to report such physicians."

The hospital administrator must also play a vital role in dealing with the impaired physician, claimed Daniel Kane, DPH, president of Mt Sinai Medical Center in Milwaukee. "Although the impaired physician's professional peers are in the best position of detecting potential problems and recommending appropriate action, the administrator must guide the process," he said.

Kane noted that the courts have ruled that the hospital could be liable for the negligence of physicians.

The second day of the program was devoted to discussing rehabilitation, detoxification and re-education and re-entry of impaired physicians. Roland Herrington, MD, Corporate Medical Director at DePaul Rehabilitation Hospital in Milwaukee, examined why some physicians become dependent on drugs or alcohol and told how his facility approaches the rehabilitative process.

Doctor Herrington called chemical dependency an "occupational hazard" in the practice of medicine and estimated that it "probably affects one in eight physicians at some time or other in the course of their professional careers." However, early diagnosis and treatment lead to successful rehabilitation in the overwhelming majority of these physicians," he said.

On the topic of psychiatric impairment, Clifford Simske, MD, Medical Director, Milwaukee Psychiatric Hospital, reiterated the idea that physicians function in an environment of chronic stress, setting high standards for themselves. "Psychologically, impaired physicians are more likely to exhibit the traits of dependency, pessimism, passivity, guilt, self-doubt, and feelings of inferiority," he said.

Doctor Simske estimated that with constant surveillance and a tightly structured aftercare program, around 60-70 percent of physicians with psychiatric impairments can return to full-practice responsibilities.

Conference moderator Harry F Weisberg, MD, gave attendees one final word of advice before they adjourned. Quoting Mark Twain, he said: "Remember, to do good is noble, but to tell others to do good is also noble but much easier. That my friends is exactly what we've been doing in the past and it is about time that each of us goes out and does something to help the impaired physician in our community."

Texts of some of the presentations made during the course of this two-day meeting, ***The Impaired Physician: Prevention, Intervention, and Rehabilitation,*** will be carried in forthcoming issues of WMJ. ■

Former Museum curator Peckham now a medical history sculptor

Sculptor Gordon Peckham, the curator of the State Medical Society's Museum at Prairie du Chien from 1960 to 1972, is currently working on a series of sculptures on the history of medicine. Presently curator of the Teaching Theatre—Museum of the Dept of Medical Humanities, Southern Illinois University School of Medicine, Peckham has thus far completed four sculptures to be cast in bronze depicting: the Medicine Man, pioneer surgeon Dr William Beaumont, Teacher Daniel Drake, and the doctor on horseback. An article highlighting the age-old wax technique he uses to cast the bronzes was featured recently in the *Prairie du Chien Courier Press.* ■

CES FOUNDATION

CONTRIBUTIONS—SEPTEMBER 1981

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for September 1981.

Unrestricted

John Allen, MD; SMS Members—*Voluntary Contributions*

Unrestricted

Mrs Richard Brown—*Aesculapian Society Membership Dues*
State Medical Society—*Grant for Wisconsin Work Week of Health*
Jerry Allen—*Museum of Medical Progress*

Memorials

Dee Miller; Noreen Krueger—*Dorothy (Parks) Reinhardt (Student Loan Fund)*
Dr-Mrs Robert E Johnston—*Dorothy (Parks) Reinhardt (Brown County Loan Fund)*
Dr-Mrs Loren Hart; Dr-Mrs Robert T Schmidt—*Michael Mascik (Brown County Loan Fund)*
Dr-Mrs Robert T Schmidt—*Ben Rosenberg; Ben Laird (Brown County Loan Fund)*
Mrs Marion P Crownhart—*Dorothy (Parks) Reinhardt (Crownhart Memorial Fund)*
Dr-Mrs Richard W Edwards—*Dorothy (Parks) Reinhardt (Museum of Medical Progress Endowment Fund)*
Mary Angell—*Dorothy (Parks) Reinhardt (Museum of Medical Progress)*
Dr-Mrs Jack D Edson; *Michael P Mehr, MD—Joseph Lubitz, MD (Joseph Lubitz, MD Memorial Fund)*
Schrank Clinic-Waupun—*Kenneth Kraemer*
Dr-Mrs Charles J Picard—*Edgar End, MD; William Grover, MD*
EJ Nordby, MD—*Mrs Roscoe McIntosh*
Maxine Gilbert—*Bill Angell*
Diane Upton; Mr-Mrs Dan Weaver; Marcella Herfel; Mr-Mrs William Guerten; Mavis & Reese Minor; SMS Staff; Joan Pyre; Mrs HD Thomsen; Leland Pomainville, MD; Robert B Murphy; Retha Jameson; Mrs Esther Fagan; Mrs K Alan Stormo; Dr-Mrs Leonard Torkelson; Mr-Mrs Joseph Rowan; Pauline M Jackson, MD; Mrs WD Hoard, Jr; EJ Nordby, MD; Patricia J Stuff, MD; Lee & Janice Johnson; American Medical Association; Bailey, Calmes & Company; William Wendle; Maxine Gilbert; Marion Erlien; Edmund & Sally White Brykit; Thomas & Mary Bednarowski; Robert & Clara Wiersma; Howard & Barbara Brower; Dr-Mrs Carl Eisenberg—*Dorothy (Parks Reinhardt*■

SMS Services Inc appoints new insurance sales representative

Craig Bottorff has joined the SMS Services Inc staff as an insurance sales representative. Craig has spent the last 12 years working with the medical profession and has an extensive background in insurance. He will be assisting in developing SMS Services Inc insurance agency and has been assigned to Dane, Rock, Jefferson, and Dodge counties.■

Craig Bottorff

SMS Physicians Alliance has two new field consultants

Two new field consultants have been named to the SMS Physicians Alliance staff. Lanny Hardy of Middleton has assumed the position vacated by the resignation of Ken Opin. Ronald Henrichs of Merrill replaces Marv Stromer.

Lanny will provide assistance to physicians in the following county medical societies: Columbia-Marquette-Adams, Dane, Grant, Green, Green Lake-Waushara, Iowa, Juneau, Lafayette, Richland, Rock, Sauk, and Vernon.

Ron's territory covers the following county medical societies: Clark (eastern half), Florence, Forest, Langlade, Lincoln, Marathon, Marinette (northern half), Oconto (northwest), Oneida, Price (southern half), Portage, Rusk, Shawano, Taylor, Vilas, and Wood.

Lanny is a native of Richland Center and has experience in association, membership recruitment, and political work over the past five years.

Ron, a native of Merrill, has previously worked as a public relations and marketing officer for the Bank of Menasha and as the executive director of the Merrill Chamber of Commerce.

As soon as they have completed their orientation and training program, information will be provided for contacting them.■

Ronald Henrichs

Lanny Hardy

MEMBERSHIP FACTS

ARE YOU A MEMBER of the State Medical Society of Wisconsin, or do you know someone who isn't? Whether you're just starting medical school, maintain a full-time practice, or are retired, SMS has a membership classification to fit your individual needs. Furthermore, in light of a recent change in membership policy, physicians may join their county and state societies and the AMA or just their county and state societies; however, AMA membership is encouraged. Dues for regular membership are $410 for SMS, $285 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF DUES CLASSIFICATION CODES

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of illness or financial hardship. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: Member who is engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy.

Emeritus: Retired members who have chosen not to renew their license.

1982 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$410	$285	Normal County Dues
Resident	41	35	Varies
Military Service	-0-	285 or 35	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-	-0-
Honorary	-0-	-0-	-0-
Retired	-0-	-0- *	-0-
Part-time Practice	205	285 *	Normal County Dues
Over Age 70	205	-0- *	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-	
Candidate—			
Freshman Year Medical Student	-0-	15	Varies
Sophomore and Succeeding Medical Student Years	10	15	Varies
Postgraduate—One	10	35	Varies

*Due to recent policy changes by the AMA, future exemptions from AMA dues will be given to those physicians who are over 70 years of age *and* are retired from practice or practice 1000 hours or less a year.

1981-82 Membership Directory to be published in January

The 1981-82 Membership Directory will be published in January for the second consecutive year. It will have the same format: State Medical Society members will be listed alphabetically by county medical society and will include the member's name, address, telephone number (if provided), and primary and secondary specialties. Earlier this month all members received a postal card with a computer-printed label as provided by the Membership Department. Members are asked to confirm the information on the label and make any corrections (including the telephone number and county medical society), returning the card to the *Wisconsin Medical Journal* as soon as possible and no later than *November 30.* To contain costs the WMJ will not include other editorial matter in the directory issue. Because of the nature of the issue additional advertising space will be offered to medical clinics, hospitals, and other patient care services.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial prepa tions, prolonged use may result in overgrowth of nc susceptible organisms, including fungi. Appropria measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not u common cutaneous sensitizer. Articles in the curre literature indicate an increase in the prevalence persons allergic to neomycin. Ototoxicity and neph toxicity have been reported (see Warning section).

Complete literature available on request from Prof sional Services Dept. PML.

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T-19 contract/reimbursement issue appears settled

The SMS Physicians Alliance Commission was informed October 16 that the State Department of Health and Social Services intends to implement new physician provider profiles in the Wisconsin Medical Assistance Program on December 1, with an increase in reimbursement of 8.7%.

Earlier, the Alliance Commission had strongly objected to the intention of DHSS not to implement new profiles pending the development of a uniform fee methodology for physician service claims.

The Alliance charged that the current physician provider agreement called for an adjustment equal to that which was applied by the federal government to the Medicare program, or a 7.5% increase over 1980. While the State Biennial Budget Bill called for a 4.5% increase, the Alliance argued that the provider agreement was the controlling factor.

Historically, adjustments are announced on July 1 of each year, although implementation of the new profiles usually occurs sometime in September. Because DHSS indicated that it would be unable to implement new profiles until December 1 of this year, the Alliance suggested that the limit be a 8.7% rather than 7.5%.

For every month of delay in profile implementation, the Alliance Commission felt the limit should be increased by 0.6%. The Department concurred with that approach, hence the additional 1.2%. ■

State Senate passes hospital reporting legislation

Under a bill passed on a voice vote by the Senate in October, hospitals will be obligated to report to the State Medical Examining Board disciplinary actions taken against medical staff.

Senate Bill 68 requires hospitals to notify the Medical Examining Board within 30 days if a physician's hospital staff privileges are revoked or reduced for 30 days or more, or if the physician resigns from the staff for 30 days or more as a result of peer investigation. Temporary suspensions due to incomplete records need not be reported.

This provision is one of a series of recommendations made by the Medical Society's Ad Hoc Committee on Quality Assurance. Other recommendations of the Ad Hoc Committee incorporated in SB 68 are:

. . .a civil immunity clause for persons who in good faith report to the Medical Examining Board information concerning possible unprofessional conduct by physicians or others licensed by the Board;

. . .a requirement that the Medical Examining Board shall notify the physician in writing of the substance of the hospital disciplinary report;

. . .an authorization that the physician or the physician's authorized representative may examine the report and place into the record a statement concerning the physician's view of the correctness or relevance of any information in the report;

. . .an authorization that the physician may institute circuit court action to expunge or amend any part of the report;

. . .an authorization allowing the Medical Examining Board to remove from the physician's record any hospital disciplinary report it deems is without merit;

. . .an authorization for the Medical Examining Board to remove a hospital disciplinary report from the physician's record if the Board determines that the physician has sufficiently improved his or her conduct or competence, and

. . .an authorization allowing the physician to petition the Medical Examining Board to remove any prior reports if there is no hospital disciplinary report filed for two consecutive years.

Senate Bill 68 is now pending before the Assembly. ■

Byrnes leaves Workers' Comp; Mattka new head

K Sue Mattka has replaced John R Byrnes as administrator of the Workers' Compensation Division of the State Department of Industry, Labor and Human Relations, Secretary-designate Lowell Jackson has announced. On September 14 Byrnes was appointed a US Attorney in Madison by Federal Judge Barbara Crabb.

Mattka will be in charge of 76 employees at the Division which supervises the payment of benefits to workers or their dependents for work-related injuries, diseases, or deaths. The Division also makes special payments to dependents of police, fire, rescue squad, and correctional officers killed in the line of duty. Mattka served as candidate recruitment director for the Republican Party for nearly two years before assuming the post of political director in 1979. Ms Mattka met with the SMS Committee on Environmental and Occupational Health in late October. ■

LEGISLATIVE UPDATE

A bill which would authorize marijuana and its derivatives to be used for therapeutic purposes duplicates an existing program operating through the State Controlled Substances Board an SMS spokesperson told an Assembly Committee last month. SMS Legislative Coordinator Don Lord said the existing program is superior to the bill being proposed by Rep David Clarenbach (D-Madison) since it approves physicians and hospital pharmacies—not patients; it does not charge the state or patients for the THC capsules, and it promotes more research into THC use. The Assembly Health and Social Services Committee later recommended the bill for passage on a 12-2 vote.

Other recent legislative action includes:

SB 80—Regulation of smoking: Passed the Senate and now goes to the Assemby for action. The bill restricts smoking in several public places such as healthcare facilities, restaurants, etc. *SMS supports.*

SB 216—Gunshot wounds: Passed the Senate on voice vote. This bill requires medical personnel to report *all* gunshot wounds and injuries received in the commission of, or as a victim of, a crime to law enforcement authorities within 24 hours. *SMS supports* the bill if it is amended to pertain to gunshot wounds only. The Society will now push for this amendment in the Assembly.

AB 422—Psychology coverage: Failed to be recommended for passage by the Assembly Insurance Committee. The bill requires all health insurance plans and contracts to cover services provided by a psychologist when the same or similar services are covered when provided by a physician. The bill, which now is most likely dead for this session, is *opposed* by SMS on the grounds that it prevents freedom of choice for the patient.

SB 603—Chiropractic coverage: Recommended for passage on a 2-1 vote by the Senate Insurance and Utilities Committee. The bill requires insurance plans and contracts to cover services provided by a chiropractor when the same or similar services are covered when provided by a physician. The bill now goes on to the Joint Finance Committee. *SMS opposes.*

SB 282—Ambulance drivers: Passed the Assembly by a 95-2 vote, the bill allows ambulance drivers, who are not licensed as EMTs, to assist in handling patients under supervision. The rendering of emergency care procedures is not permitted. This bill now goes to the Governor for his signature. *SMS supports.*

AB 555—Radioactive Waste Review Board: Passed the Assembly by a vote of 78 - 19, this bill creates a Radioactive Waste Review Board to deal with the Federal government on all matters relating to the long-term disposal of high-level radioactive waste. *SMS supports.*

SB 536—Look-alike drugs: Passed the Senate on a unanimous vote, the bill restricts the advertising and commercial trafficking of substances that resemble controlled substances. The bill now goes to the Assembly. *SMS supports.* ■

WHCLIP Board looks at claims threshold, minimum coverage

The WHCLIP/Fund Board of Governors met on October 14 and took action on several issues which will affect the Patients Compensation Fund.

Concerned with the ever-increasing number of claims penetrating the Fund, the Board had previously appointed a committee to evaluate the adequacy of the $200,000 per claim and $600,000 per year threshold to the Fund. Based on recommendations from this committee, the Board decided to retain the $200,000/$600,000 threshold but take steps necessary to contract with an insurance carrier to perform claims management functions for the Fund.

This is currently being done by the Fund administrator and claims committee, but due to the volume of claims involved, a more structured approach was thought to be preferable.

The Board also decided to seek legislation to increase the level of medical liability insurance coverage required by law. Currently all practicing physicians must, by law, carry coverage of at least $100,000 per claim and $300,000 per year. However, because the Fund is liable only for that portion of a claim beyond $200,000, the potential of a $100,000 gap exists for any physician carrying the minimum coverage.

The Board will introduce legislation to tie the amount of the minimum mandated coverage to the Fund threshold. Under this approach, the minimum coverage would be increased to $200,000 per claim and $600,000 per year. ■

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Physician Briefs

*Physician members of State Medical Society of Wisconsin

Gregory L Darrow, MD,* Janesville, recently received the degree of Fellow of the American Academy of Family Physicians. Doctor Darrow graduated from the Indiana University School of Medicine and completed his family practice residency at Bayfront Medical Center, University of South Florida. He is associated in practice with Rocco J Vitacca, MD.*

Julio C Davila, MD,* Wausau, recently delivered two invitational lectures to the annual conference of the Alliance for Engineering in Medicine and Biology in Houston, Texas. The topics were "Normal and Pathologic Anatomy of the Mitral and Aortic Valves" and "Mechanical Factors in Design and Choice of Prosthetic Valves."

Rudolph C Hecht, MD,* Madison, recently was elected Secretary General Consul of Mexico in Madison by the Consular Corps of Wisconsin at its annual meeting. Doctor Hecht is on the full-time faculty of the University of Wisconsin Medical School, Madison, in the Department of Family Medicine and Practice.

David A Manke, MD, Bruce P Fenster, MD, and **Diane L Fenster, MD,** recently joined the medical staff of the West Side Clinic, SC, Green Bay. Doctor Manke graduated from the University of Cincinnati and served his residency in general and peripheral vascular surgery at Iowa Methodist Medical Center in Des Moines, Iowa. Doctor Bruce Fenster graduated from Pritzker School of Medicine at the University of Chicago and served his residency in internal medicine at the University of Cincinnati Medical Center. Doctor Diane Fenster, pediatrician, also graduated from the Pritzker School of Medicine at the University of Chicago and served her residency at Children's Hospital Medical Center in Cincinnati, Ohio.

James E Burwitz, MD,* Mauston, recently began his medical practice in the New Lisbon Medical Clinic. Doctor Burwitz graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency in Wausau.

James E Madsen, MD, Stanley, recently joined the medical staff of the Marshfield Clinic-Stanley Center. Doctor Madsen graduated from the University of Nebraska Medical Center and completed his residency at St Mary's Hospital Medical Center in Madison. Prior to moving to Stanley, Doctor Madsen had practiced medicine in Hobbs, New Mexico.

William N Watson, MD, recently opened his medical practice in the Town of Summit. A graduate from the University of Vanderbilt Medical School, Nashville, Tenn, Doctor Watson completed his internship at Stanford University Hospital in California. His residency was completed at the University of Hawaii and the University of Pittsburgh. He served for two years with the US Public Health Service and for the past year has been on the staff of the Medical College of Wisconsin, Milwaukee, Division of Child Psychiatry, and the Child and Adolescent Treatment Center at the Mental Health Complex, Milwaukee County.

Bradley L Manning, MD,* Madison, recently opened his medical office for practicing plastic surgery, including reconstructive, cosmetic and hand surgery. He graduated from the University of Illinois College of Medicine, Chicago, Ill, and completed his residency in surgery and plastic surgery at the University of Wisconsin Medical School, Madison. He is a diplomate of the American Board of Surgery.

James Tandias, MD, recently became associated with Kenneth H Yuska, MD* in Marinette. Doctor Tandias graduated from the University of Minnesota Medical School and served an internship at Hennepin County Medical Center in Minneapolis. He completed his residency in orthopedic surgery at the Veterans Administration Medical Center in Minneapolis.

Carol Blum, MD, Ashland, has been appointed to the medical staff at Memorial Medical Center in Ashland. Doctor Blum graduated from Kansas University Medical School and completed her residency at the Kansas University Medical Center. She came to Ashland to enter into a medical practice partnership with the late Bruce C Prentice, MD. Doctor Blum is certified by the American College of Anesthesiologists.

Lynn D Koob, MD,* who is associated with the Indianhead Medical Group in Rice Lake, recently completed the certification requirements of the American Board of Surgery. Doctor Koob completed his general surgery residency at the Gundersen Clinic in LaCrosse.

Kimberly M Thompson, MD, Superior, recently became associated with the East End Clinic Ltd in Superior. Doctor Thompson graduated from the University of Wisconsin Medical School in 1978 and completed his family practice residency from the Duluth Family Practice Center.

Gerald C Kempthorne, MD,* Spring Green, recently received "Physician of the Year Award" for his contribution to the care of the elderly in nursing homes and leadership in the field of geriatrics. See separate story in ORGANIZATIONAL section.

Peter Holm, MD, Chippewa Falls, recently became a member of the medical staff of St Joseph's Hospital. Doctor Holm graduated from the Northwestern University School of Medicine, Chicago, and served his internship at Loma Linda University Hospital, Loma Linda, Calif. His residency, in ophthalmology, was completed at the University of Wisconsin Hospital and Clinics in Madison.

Eric S Heaney, MD,* Mauston, has joined the medical staff of the Mile Bluff Medical Center. He graduated from the University of Wisconsin Medical School, Madison, and completed his internship at the University of Oregon in Portland. His residency was served at the University Health Science Center in the Family Practice Residency Program, Madison. Prior to joining the medical center in Mauston, Doctor Heaney was working in the emergency room of St Clare Hospital in Baraboo.

Paul Ippel, MD, Chippewa Falls, recently became a member of the medical staff of St Joseph's Hospital. Doctor Ippel graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency with the Eau Claire Family Practice Residency Program. He is associated with Steven D Cook, MD.*

David Ehlenz, MD, who is associated with Larry L Hanley, MD,* Chippewa Falls, recently became a member of the medical staff of St Joseph's Hospital in Chippewa Falls. Doctor Ehlenz graduated from the Mayo Medical School in Rochester, Minn, and completed his residency at the St Francis Hospital/Mayo Clinic Family Practice Residency Program in LaCrosse.

Steven S Leigel, MD,* Chippewa Falls, recently became a member of the medical staff of St Joseph's Hospital. Doctor Leigel graduated from the University of Wisconsin Medical School, Madison, and completed his residency at the University of Wisconsin Hospital and Clinics in Madison. Doctor Leigel is in the Department of Radiology.

Erick P Kindwall, MD* Brookfield, recently was elected president of the Undersea Medical Society, an international association of 1600 physicians and scientists active in undersea medicine and its supporting sciences. Doctor Kindwall is director of hyperbaric medicine at St Luke's Hospital, Milwaukee. He was assistant director of the US Navy School of Submarine Medicine, New London, Conn, and also is assistant adjunct clinical professor of pharmacology in the section of environmental medicine at the Medical College of Wisconsin.

Sisinio T Lim, MD, Marshfield, has joined the medical staff of the Marshfield Clinic in the Department of Anesthesiology. Doctor Lim graduated from Debu Institute of Medicine in The Philippines, and served his internship at Little Company of Mary Hospital in Evergreen Park, Ill. He completed his residency at Mount Sinai and Cook County hospitals in Chicago.

Jane A Gehlsen, MD, Marshfield, recently became a member of the medical staff of the Marshfield Clinic. Doctor Gehlsen graduated from the University of Minnesota School of Medicine and served her internship and residency at the Medical College of Wisconsin, Milwaukee. She served an oncology fellowship at the Memorial-Sloan Kettering Cancer Center in New York City and also completed a fellowship in hematology at the New York University Medical Center. ■

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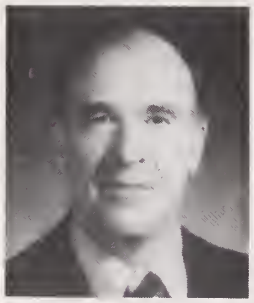
POLK: At a recent meeting of the Polk County Medical Society, Richard Reece, MD, Minneapolis, Minn, presented a paper entitled "Current Medical Conditions in China."

Dane County Medical Society honors two

Cyril M Hetsko, MD, Madison, was awarded the Presidential Award and John LaBissoniere was awarded the Board of Trustees Award of the Dane County Medical Society at a special Society function October 16.

The Presidential Award is bestowed upon Dane County Medical Society members who have provided exceptional service to the Society. Doctor Hetsko was recognized for his work in developing the Dane County Health Maintenance Program. Since 1977, Doctor Hetsko has served as chairman of the WPS Health Maintenance Program Liaison Committee.



Mr LaBissoniere

Doctor Hetsko

A native of Montclair, New Jersey, Doctor Hetsko received his medical degree from the University of Rochester in New York State. He has practiced internal medicine at the Dean Clinic in Madison since 1975.

The Board of Trustees Award is granted to persons who have given exceptional service in the healthcare field to the citizens of Dane County.

Mr LaBissoniere received the award because of his outstanding service as executive assistant of the Dane County Medical Society during the past five years.

In addition to his role with the Dane County Medical Society, LaBissoniere has been associated with the State Medical Society of Wisconsin for more than 27 years in its health insurance activities and currently as Peer Review Coordinator. He is a graduate of Marquette University in Milwaukee. ■

POLK: Speaking at the October meeting of the Polk County Medical Society was Robert Geist, MD, St Paul, Minn, on "What you wanted to know about children's urinary problems and were afraid to ask." William R Byrne, MD, Amery, host of the meeting, is scheduled to attend the Leadership Conference in Brookfield in November. There were 12 members present; election of officers will take place at the November meeting.

OUTAGAMIE: Thirty-three members and guests were present at the Outagamie County Medical Society October meeting to hear Mr Thomas Murphy of Milwaukee speak on "Get Off Your Assets," a financial presentation. Also speaking was Kris Bjurstrom, field consultant of the SMS Physicians Alliance Division, on Medicare/Medicaid Reimbursement.

SHEBOYGAN: Thomas Petrie, Representative to the United States Congress, spoke on legislative issues at the October meeting of the Sheboygan County Medical Society. Mr Petrie discussed aspects of budget-cutting efforts, attempts to reduce regulations and paperwork, and particular efforts to remove tobacco subsidy. He also answered questions regarding Social Security costs and problems. Seven physicians were accepted to membership and James B Kuplic, MD, president of the Society, announced formation of a cost-containment committee. There were 44 members present at the meeting.

WINNEBAGO: At its October 1 meeting the Winnebago County Medical Society had Henry S Schutta, MD* as its guest speaker. Doctor Schutta is chief of the Department of Neurology at University Hospital and Clinics, Madison, and presented a paper on "Neurologic Complications of Carcinoma." Timothy T Flaherty, MD* of Neenah, gave a review on the State of Wisconsin's recent decision regarding Medicaid reimbursement. There were 40 members and 5 guests present. ■

Medical history speaker available

Need a speaker for an upcoming county medical society meeting? Leland C Pomainville, MD, Wisconsin Rapids, will present half-hour programs on the history of medicine upon request. Doctor Pomainville, who is an authority on medical history and the State Medical Society's historian, will speak on several topics including: "Indian Medicine," "Sitting Bull and Medicine Man," "Peyote Ceremony," "The Wounded Presidents," "Civil War Medicine," and "Tetanus Convulsions During a Polio Epidemic"—showing how medicine has changed from early days to now. For more information contact Doctor Pomainville at 521 Eighth Street South, Wisconsin Rapids, WI 54494. ■

Specialty Societies

*Physician members of State Medical Society of Wisconsin

Wisconsin Society of Internal Medicine recently installed Russell A Quirk, MD,* Racine, as president, at the annual meeting and scientific program held in LaCrosse. He succeeds Kenneth I Gold, MD* of Beloit. In other actions Joseph J Mazza, MD,* Marshfield, was named president-elect and Philip J Dougherty, MD,* Menomonee Falls, was elected secretary-treasurer. Doctor Quirk was elected to the Society's governing council in 1978 and has served as chairman of the Society's Task Force on Medical Liability and as a member of the program and membership committees. He also is a delegate to the American Society of Internal Medicine. Others elected were: Thomas P Driscoll, MD,* Wauwatosa, and Anthony P Ziebert, MD,* Milwaukee, to three-year terms on the governing council; and Cyril M Hetsko, MD,* Madison, to a two-year term. Continuing council members are Doctors Gold, James A Means,* Milwaukee; James R Mattson,* Green Bay; Charles S Geiger Jr,* West Bend, and Edwin L Overholt,* LaCrosse. Serving as an ex-officio member of the council is Charles L Junkerman, MD,* Milwaukee, who is the American College of Physicians' governor for Wisconsin.

American College of Emergency Physicians recently accepted the resignation of its executive director, Mr Arthur E Auer. He will remain on the staff until a new executive director is hired. Mr Auer became executive director in 1970 when the College had 3000 members. Under his leadership, ACEP has grown to include over 10,800 members in the United States, Canada and Puerto Rico. ■

News Highlights

*Physician members of State Medical Society of Wisconsin

American Medical Association Education and Research Foundation (AMA-ERF) has named 18 senior medical students as the 1981 Rock Sleyster Scholars. Each student will receive a $2000 grant for the 1981-82 school year. The scholarships have been awarded to the medical students on the basis of scholarship, financial need, and demonstrated interest in psychiatry, according to George H Mills, MD, AMA-ERF president. The scholarship program was made possible by a $380,000 bequest of the late Mrs Clara S Sleyster of Shorewood, Wisconsin, a suburb of Milwaukee, establishing a memorial fund to honor her husband Rock Sleyster, MD, president of the American Medical Association in 1939-40. This year's Rock Sleyster scholars include two from Wisconsin: Mary C Olson, University of Wisconsin Medical School (Born: Wausau, Wisconsin; age: 26; U of Wis '78 BS Pharmacy; Rho Chi & PKP; 6 college awards; interest: adult psychiatry with emphasis on family therapy); and Lory David Wiviott, Albert Einstein College of Medicine (Born: Milwaukee, Wisconsin; age: 25; U of Wis '78 BS Philosophy, Chemistry; one publication; goal: Psychiatrist).

Cantwell-Peterson Clinic, Shawano, has announced Richard Ferrell as the new administrator of the Clinic. A veteran of 12 years in healthcare administration, he has spent the last three years in clinic administration in Iowa. Mr Ferrell has a master's degree from the University of Iowa in hospital and healthcare administration. ■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored by organizations accredited for these activities. The State Medical Society of Wisconsin congratulates the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

SEPTEMBER 1981

*Anderson, Clifford, Racine
Anderson, I Jeanne, Madison
Augustine, Raymond J, Eau Claire
*Burwitz, James E, New Lisbon
Castleberg, David L, Durand
*Edwards, Richard W, Richland Center
Fishman, Paul A, Milwaukee
*Frank, Ralph C, Eau Claire
*Knechtges, Thomas E, Elm Grove
*Mautz, William T, Eau Claire
*Mayersak, Jerome S, Merrill
*Peters, Mary Ellen, Madison
*Schultz, Richard O, Milwaukee
*Wilson, Jeffrey W, Mequon ■

*Members of the State Medical Society of Wisconsin

Obituaries

Joseph W Steckbauer, MD, 86, Manitowoc, died Aug 19, 1981 in Manitowoc. Born Apr 20, 1895 in Oshkosh, Doctor Steckbauer graduated from Rush Medical College, Chicago, in 1920. He served his internship at St Louis City Hospital and established his medical practice in Manitowoc in 1926. He was a veteran of World War I. Doctor Steckbauer was a member of the "50 Year Club" of the State Medical Society of Wisconsin; a member of the Manitowoc County Medical Society, and the American Medical Association. Surviving are his widow, Frances, and a daughter, Helen, of Pulaski.

Richard D Jeffries, MD, 29, Shawano, died Aug 22, 1981 in Shawano. Born Jan 11, 1952 in Granite City, Ill, he graduated from the University of Wisconsin Medical School, Madison, and completed his residency training at the Family Practice Clinic in Duluth, Minn. Doctor Jeffries had been a member of the medical staff of the Cantwell-Peterson Clinic in Shawano since 1979. He was a member of the Shawano County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Rita, his parents, Doctor and Mrs Donald A Jeffries, Shawano; four sisters, Mrs Daniel (Jeanne) Weiland, Appleton; Mrs Mark (Ellen) Heideman, Shawano; Anne Jeffries, Green; and Kathryn Jeffries of Shawano.

Todor Gencheff, MD, 59, Madison, died Aug 29, 1981 in Madison. Born Nov 22, 1921 in Stara-Zagora, Bulgaria, Doctor Gencheff graduated from the Faculty of Medicine of the Cervenko Higher Institute of Medicine in Sofia, Bulgaria. He completed internship and residencies in Bulgaria, Yugoslavia, Canada, and Scotland. Doctor Gencheff had been on the medical staffs at the Lakeview Medical Center, Methodist Hospital, and Central Wisconsin Center. He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Surviving are his widow; and three sons, Gary, Glenview, Ill; Dr Chris, Madison; and Nelson of Madison.

Quentin C Case, MD, 52, Oshkosh, died Sept 10, 1981 in Oshkosh. Born Mar 11, 1929 in Racine, Doctor Case graduated from St Louis University Medical School in 1956 and served his internship at St Louis City Hospital. His residency in pediatrics was completed at Milwaukee Children's Hospital and he served in the United States Air Force from 1959 to 1961. Doctor Case had been on the medical staff of the Winnebago Mental Health Institute for 14 years. Surviving is his father.

Alf F Borge, MD, 56, former Mauston physician, died Sept 11, 1981 in Fargo, ND. Born Aug 2, 1925 in Cambridge, Doctor Borge graduated from the University of Wisconsin Medical School, Madison, in 1925. His internship was completed at Memorial Hospital, South Bend, Ind, and at the Veterans Administration Hospital, Wood, Wis. Surviving are his widow; three daughters, Mrs Wayne (Carol) Reitz, Rustburg, VA; Ann Borge, Tempe, AZ, and Lila at home; three sons, John, Moorhead, ND; and David and Richard of Fargo, ND.

Harry Beckman, MD, 89, Center Sandwich, New Hampshire, died Sept 16, 1981 in New Hampshire. Born Aug 14, 1892 in Louisville, KY, Doctor Beckman graduated from the University of Louisville School of Medicine in 1921. He served his internship in New York City and in 1932 became an instructor in the Department of Physiology and Pharmacology at Marquette University School of Medicine, Milwaukee. In 1926 he became a professor and director of the Department of Pharmacology at Marquette University and served in that capacity until his retirement as director in 1961. From 1930-1931 he studied at the University of Vienna.

Doctor Beckman
(1959 photo)

From 1945-1961, Doctor Beckman co-authored the series "Comments on Treatment" in the *Wisconsin Medical Journal* and also the series "Therapeutic Dilemmas." In 1959 he received the "Council Award" from the State Medical Society of Wisconsin, and in 1961 he received the "Distinguished Service Award" from Marquette University School of Medicine. In 1961 he retired from his administrative duties in the Department of Pharmacology but continued his research, writing, and as a consultant at Columbia and Milwaukee County General Hospitals until moving to New Hampshire in 1971.

In 1967 the *Wisconsin Medical Journal* published a "Festschrift" issue honoring him. He was the author of the popular medical textbook entitled "Treatment in General Practice."

Doctor Beckman was a member of the Central Society for Clinical Research; Society for Experimental Biology and Medicine; American Society for Pharmacology and Experimental Therapeutics; Federation of American Societies for Experimental Biology; American Heart Association; American Chemical Society; American Medical Association; American Therapeutic Society; American Association for the Advancement of Science; American Society of Tropical Medicine and Hygiene; American College of Clinical Pharmacology and Chemotherapy; New York Academy of Medicine; Royal Society of Tropical Medicine and Hygiene; Wisconsin Heart Association; and served as president of the Milwaukee Academy of Medicine and American Society for Pharmacology and Experimental Therapeutics.

Max M Lavine, MD, 71, Fort Lauderdale, Fla, died Sept 18, 1981 in Fort Lauderdale. Born Jan 24, 1910 in Superior, Doctor Lavine graduated from the Marquette University School of Medicine in 1939 and served his

internship at St Francis Hospital in Peoria, Ill. Doctor Lavine served in the United States Air Force during World War II and returned to Superior in 1945. Founder of the Superior Clinic, he was a past chief-of-staff of Superior Memorial Hospital and past president of the Douglas County Medical Society. He also was a member of the State Medical Society of Wisconsin and the American Medical Association. Surviving are his widow, Seena; one daughter, Rita, Boca Raton, Fla, and a son, Howard Goldfine of Minneapolis, Minn.

Wilson Weisel, MD, 67, prominent Milwaukee physician, died Sept 22, 1981 in River Hills. Born June 4, 1914 in Alexandria, Neb, Doctor Weisel graduated from Harvard Medical School in 1938 and served his internship at St Joseph's Hospital in Milwaukee. His residency was completed at the Mayo Clinic, Rochester, Minn. Doctor Weisel served as a surgical consultant at the Veterans Administration Hospital, Wood, from 1946 until 1979 when he retired. He also was chairman of the Department of Surgery at St Joseph's Hospital and was chairman of the Department of Thoracic-Cardiovascular Surgery at the old Marquette School of Medicine. He was a member of the Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Amy; a daughter, Amy Burke of Bayside; and two sons, Thomas W, Ross, Calif, and Richard D of Toronto, Ontario. ■

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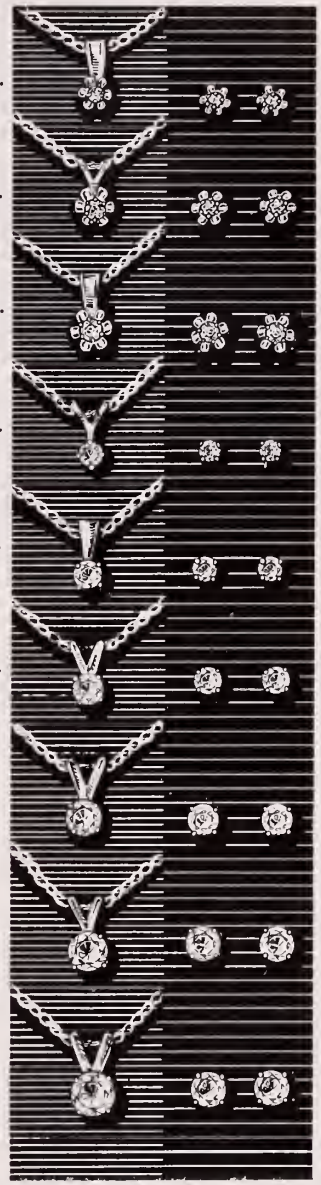

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Membership Directory UPDATE

Prepared from the September 22, 1981 Membership Report and from member notifications to Wisconsin Medical Journal for updating the 1980-81 Membership Directory published in the January 1981 issue.

Physicians are reminded that the newly revised Constitution and Bylaws, as adopted by the 1981 House of Delegates and printed in the June 1981 *Blue Book* issue, state that "any member whose current year's dues have not been received by the secretary of this Society by May 15 shall be deemed in arrears and his name shall be removed from the membership rolls of his county society and this Society until such time as full dues for the current year have been received." Reelected members are those physicians who previously were members. Reinstated members are those physicians removed from membership who have been returned to the roster without a break in membership. Physicians removed from membership include those who resigned, moved out of state, or failed to pay current dues.

ASHLAND-BAYFIELD-IRON

Deceased members

Prentice, John W—Aug 5, 1981

BARRON-WASHBURN-BURNETT

Reinstated members

GS
Fogarty, James P
Rt 2 Box 304-C
Chetek WI 54728

Address changes

New	*Old*
GS RET **Matson, Kenneth L** 10738 Santa Fe Dr Sun City AZ 85351	Rt 1 Box 225 Sarona WI 54870
P **Rugowski, James A** 3903 State Street Rd Eau Claire WI 54701	Rt 1 Box 146A Cumberland WI 54829

BROWN

Reinstated members

GP
Guthrie, John M
1751 Deckner Ave
Green Bay WI 54302

CRAWFORD

New Members

IM RHU
Kilpatrick, Frank W
30 South Henry St
Madison WI 53703

DANE

New members

CD NM
Besozzi, Myrwood C
600 Highland Ave
Madison WI 53792

DANE continued

New members

(PGI-82)
Bullis, Gregory G
1910 Monroe St, Apt J
Madison WI 53711

P
Dichter, Howard N
2239 Keyes Ave
Madison WI 53711

PM
Kienker, Karen A
234 Randolph Dr, #119-D
Madison WI 53217

OPH
Lange, Ronald H
410 N Meadow Lane
Madison WI 53705

FP
Marina, Otilia A
2411 Parmenter St
Middleton WI 53562

OTO PS
McDonald, Michael H
2370 County Highway MM
Oregon WI 53575

OBG
Portman, Edward M
1020 Regent St
Madison WI 53715

IM
Rosenberg, William H
7606 Knights Circle
Middleton WI 53562

NEP IM
Shelp, Weldon D
309 W Washington Ave
Madison WI 53703

Address changes

New	*Old*
PTH **Brown, Arnold L** 1205 Med Sciences Ctr 1300 University Ave Madison WI 53706	610 N Walnut St Madison WI 53706
FP **Heaney, Eric S** 510 Tremont St Mauston WI 53948	1214 Drake St Madison WI 53715
OBG **Jones, Judson E** 285 Carriage Hill Dr Aurora IL 60506	2132 Allen Blvd Middleton WI 53562
IM **Lechmaier, Timothy E** 1313 Fish Hatchery Rd Madison WI 53715	Madison WI 53711
TS GS **Longley, B Jack** 14 Merlham Dr Madison WI 53705	1713 Summit Ave
OTO **Miller, Gary T** 7461 Colosseum Ct, #4 Rockford IL 61107	1119 East Wakeman Wheaton IL 60187
GP **Peterson, Rodney K** 3220 Giehler Rd Stoughton WI 53589	314 S Division St

DANE continued

Address changes

New	*Old*
PTH EM	
Selliken Jr, Joseph	
1094 Dawn Lane	213 N Brooks St
Terre Haute IN 47802	Madison WI 53715
IM	
Straughn, Robert A	
263 Emporia, #4	428 Lily Dr
San Antonio TX 78209	Madison WI 53713
OPH	
Toussaint Jr, Norbert F	
5838 Timberland Trail	6411 Bridge Rd
Fitchburg WI 53711	Madison WI 53713
P	
Weffenstette, Bruce E	
N77 W5411 Bywater Lane	600 Highland Ave
Cedarburg WI 53012	Madison WI 53792

Reinstated members

IM PUD	PTH
Birnbaum, Marvin L	**Connors, Dean M**
600 Highland Ave	720 S Brooks St
Madison WI 53792	Madison WI 53715
P	IM
Clinton, Gerald L	**Jensen, Norman M**
2727 Marshall Ct	6210 Davenport Dr
Madison WI 53705	Madison WI 53711

Deceased members

Gencheff, Todor—Aug 29, 1981

County society transfers

IM	
Johnson, Gary A	from: Wood
2509 Homestead Rd	
Madison WI 53711	
Gonnering, Russell S	to: Milwaukee

Removed from membership

Erbach, Thomas J

EAU CLAIRE-DUNN-PEPIN

Address changes

New	*Old*
GS	
Cameron, William G	
250 Palmer Blvd	
c/o 6 Lakes CC Estates	5575 North Shore Dr
North Fort Myers FL 33903	Eau Claire WI 54701
GS	
Haumschild, Ronald L	
810 Parkwood	810 Kimberly St
Toledo OH 43620	Eau Claire WI 54701

FOND DU LAC

Address changes

New	*Old*
FP	
Nelsen, Paul D	
635 W Oshkosh St	
PO Box 323	669 Thorne St
Ripon WI 54971	
PS	
Pengtovong, Lerthai	
1035 Mary Hill Park	1000 North Oak Ave
Fond du Lac WI 54935	Marshfield WI 54449

GREEN

DR PDR
Jerisha, John A
817 15th Ave
PO Box 322
Monroe WI 53566

GREEN LAKE-WAUSHARA

Deceased members

Demke, Robert L—Aug 15, 1981

JEFFERSON

Address changes

New	*Old*
OPH	
Burzynski, Eugene E	
1501 Oconomowoc Ave	1518 Doctors Court
Watertown WI 53094	

KENOSHA

Address changes

New	*Old*
ORS	
Ansari, Aftab A	
3200 Sheridan Rd	723 58th St
Kenosha WI 53140	
IM	
Ortiz, Simeon B	
3200 Sheridan Rd	3618 8th Ave
Kenosha WI 53140	
GP	
Rustia, Ricardo M	
3200 Sheridan Rd	9245 First Ave
Kenosha WI 53140	

LACROSSE

Address changes

New	*Old*
OTO PS	
Ford, Charles N Jr	
600 Highland Ave	
F4/270 UW CSC	1836 South Ave
Madison WI 53792	LaCrosse WI 54601

LA CROSSE continued

Reinstated members

HEM IM
Keimowitz, Rudolph M
1836 South Ave
LaCrosse WI 54601

MANITOWOC

Deceased members

Steckbauer, Joseph W—Aug 19, 1981

MILWAUKEE

New members

CHP P
Andersen, John T
409 E Silver Spring Dr
Whitefish Bay WI 53217

D
Cantieri, John S
324 E Wisconsin Ave
Milwaukee WI 53202

OTO
Kleiner, Harvey
2040 W Wisconsin Ave
Milwaukee WI 53233

DR R
Lipchik, Elliot O
950 North 12th St
Milwaukee WI 53233

OPH
Suson, Elieser B
2300 Mayfair Rd
Milwaukee WI 53226

OBG
Tanner, Russell E
5631 N Mohawk Ave
Milwaukee WI 53217

PM
Thoppil, Ephrem
2900 W Oklahoma Ave
Milwaukee WI 53217

PD
Walvisch, Steven G
10243 W National Ave
West Allis WI 53227

GS CDS
Wollheim, Donald A
2500 N Mayfair Rd, #401
Wauwatosa WI 53226

County society transfers

OPH
Gonnering, Russell S
11645 Diane Dr
Wauwatosa WI 53226
from: Dane

Reinstated members

PD
Mellencamp, Frank J
3003 W Good Hope Rd
Milwaukee WI 53209

A IM
O'Connor, Robert D
5733 North Kent Ave
Milwaukee WI 53217

Address changes

New	*Old*
GS **Bakaleinik, Maurice** General Delivery Duluth MN 55806	PO Box 17401 Milwaukee WI 53217
U **Bourne, Charles W** 3003 W Good Hope Rd PO Box 17300 Milwaukee WI 53217	Milwaukee WI 53209
OBG **Boyd Jr, Andrew** 3003 W Good Hope Rd PO Box 17300 Milwaukee WI 53217	Milwaukee WI 53209
R **Brutvan, F Martin II** 3066 North 49th St Milwaukee WI 53210	729 Monroe Ave South Milwaukee WI 53172
CHP N **Davis, Jean P** 3003 W Good Hope Rd PO Box 17300 Milwaukee WI 53217	Milwaukee WI 53209
GP **Hermann, Alford H** 901 W Green Tree Rd Milwaukee WI 53217	2707 North 54th St Milwaukee WI 53210
IM CD RET **Jermain, William M** 9301 N 76th St, #316 Milwaukee WI 53233	7908 N Boyd Way Milwaukee WI 53217
IM NEP **Larson, Lawrence S** 3003 W Good Hope Rd PO Box 17300 Milwaukee WI 53217	Milwaukee WI 53209
D **Levenson, Ina G** 2011 Tenth Ave South Milwaukee WI 53172	3800 S 27th St Milwaukee WI 53222
PD OS **Mabini Jr, Francisco M** 5720 W Oklahoma Ave Milwaukee WI 53219	5757 W Oklahoma Ave
R **Maddison, Frank E** 2750 North Menomonee River Parkway Milwaukee WI 53222	2342 N 91st Street Wauwatosa WI 53226
FP **Moy, Raymond W** 6917 W Oklahoma Ave Milwaukee WI 53219	2243 N Prospect Ave Milwaukee WI 53209
GS **Redlin, Russell R** c/o Carriage Place 77-500 Interstate 10 Indio CA 92201	6440 Briarwood Lane Rt I Waterford WI 53185
GS VS **Schmidt, Robert M** 3003 W Good Hope Rd PO Box 17300 Milwaukee WI 53217	Milwaukee WI 53209
NS **Suberviola, P Daniel** 8771 N Pelham Parkway Milwaukee WI 53217	3070 N 51st St Milwaukee WI 53210

MILWAUKEE continued

Address changes

New	*Old*
GS	
Thomas, Walton D 3003 W Good Hope Rd PO Box 17300 Milwaukee WI 53217	Milwaukee WI 53209
IM	
Wartenberg, Alan A 8700 W Wisconsin Ave Milwaukee WI 53226	10243 W National Ave West Allis WI 53223
OBG	
Werner, David J 5631 N Mohawk Ave Milwaukee WI 53217	425 E Wisconsin Ave Milwaukee WI 53202
IM	
Willson, Donald M 3003 W Good Hope Rd PO Box 17300 Milwaukee WI 53217	Milwaukee WI 53209

MONROE

Address changes

New	*Old*
P	
Wade, Reynolds W 6813 Londonderry Lane Fort Wayne IN 46815	VA Medical Center Tomah WI 54660

OUTAGAMIE

Address changes

New	*Old*
R ON	
Larkin, Dixon F 447 North 100 East 447 Orem UT 84057	3469 Terrace View Dr Salt Lake City UT 84109

PORTAGE

New members

ORS
Kozisek, John A
500 Vincent St
Stevens Point WI 54481

RACINE

Address changes

New	*Old*
IM	
De Groot, Henry E 3803 Spring St, #305 Racine WI 53405	3801 Monarch Dr

ROCK

Address changes

New	*Old*
FP OTO	
Holmes, John F 24 Hilltop Dr Milton WI 53563	533 Vernal Ave Milton Junction WI 53564

SAUK

Address changes

New	*Old*
GP	
Stadel, Ernest V PO Box 376 Reedsburg WI 53959	1900 N Dewey St

SHEBOYGAN

Address changes

New	*Old*
GP	
Heinz, Harold N 1030 Leisure World Mesa AZ 85206	1930 N 8th St Sheboygan WI 53081
GP	
Huibregtse, Willard G 3730 N 12th Place Sheboygan WI 53081	1011 N 8th St

SHAWANO

Deceased members

Jeffries, Richard D—Aug 22, 1981

WALWORTH

Address changes

New	*Old*
IM	
Werbel, Harold J 1839 Chaise Dr Carson City NV 89701	569 Laurel Heights Delavan WI 53115

WAUKESHA

Address changes

New	*Old*
DR	
Burgos, Rudolfo G N9 W29304 Thames Rd Waukesha WI 53186	18545 Le Chateau Dr Brookfield WI 53005
GP	
Steinmetz, Thomas E W176 N9724 Riversbend Circle East Apt 5 Germantown WI 53022	W199 N11475 Rosewood

Reinstated members

IM PUD
Neumann, Jane L
725 American Ave
Waukesha WI 53186

WINNEBAGO

Address changes

New	*Old*
P	
Kelley, Thomas J PO Box 266 Butte Des Morts WI 54927	105 Washington Ave Oshkosh WI 54901
GP	
King-Kubiak, Mary K 8042 Old E Rd Omro WI 54963	Rt 1

WOOD

New members

1M
Aasen, Mike D
715 East 4th St
Marshfield WI 54449

(PG1-82)
Claflin, Katherine
1000 North Oak Ave
Marshfield WI 54449

(PG1-82)
McCormick, Jerry M
1503 S Locust Ave, #6
Marshfield WI 54449

(PG-1-82)
Pesicka, Gary
604 East 2nd St
Marshfield WI 54449

(PG1-82)
Hubert, Bruce C
1010 Sawyer Dr, #206
Marshfield, WI 54449

Knutson, Roger S
Rt 4 Box 110
Marshfield WI 54449

(PG1-82)
Kruger, Robert A
1000 North Oak Ave
Marshfield WI 54449

(PG1-82)
Pollock, Stephen C
311 W Kalshed St, #106
Marshfield WI 54449

(PG1-82)
Snyder, Wayne C
865 W 17th St
Marshfield WI 54449

D
Tauscheck, Aloys L
1000 North Oak Ave
Marshfield WI 54449

1M
Wittman, William J
1000 North Oak Ave
Marshfield WI 54449

Address changes

New	*Old*
DR **Kimmel, Roger L** 610 S Cypress Ave Marshfield WI 54449	1000 North Oak Ave

Deceased members

Debus, Elmer E—May 26, 1981

County society transfers

Johnson, Gary A to: Dane■

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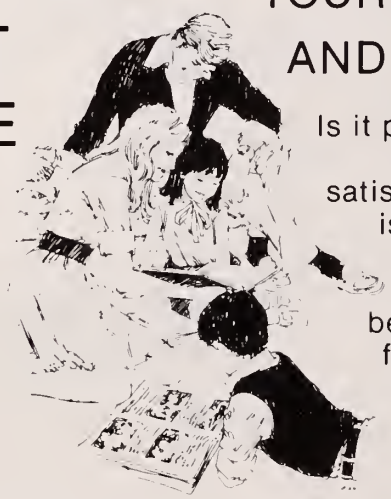

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Wauwatosa, WI 53226
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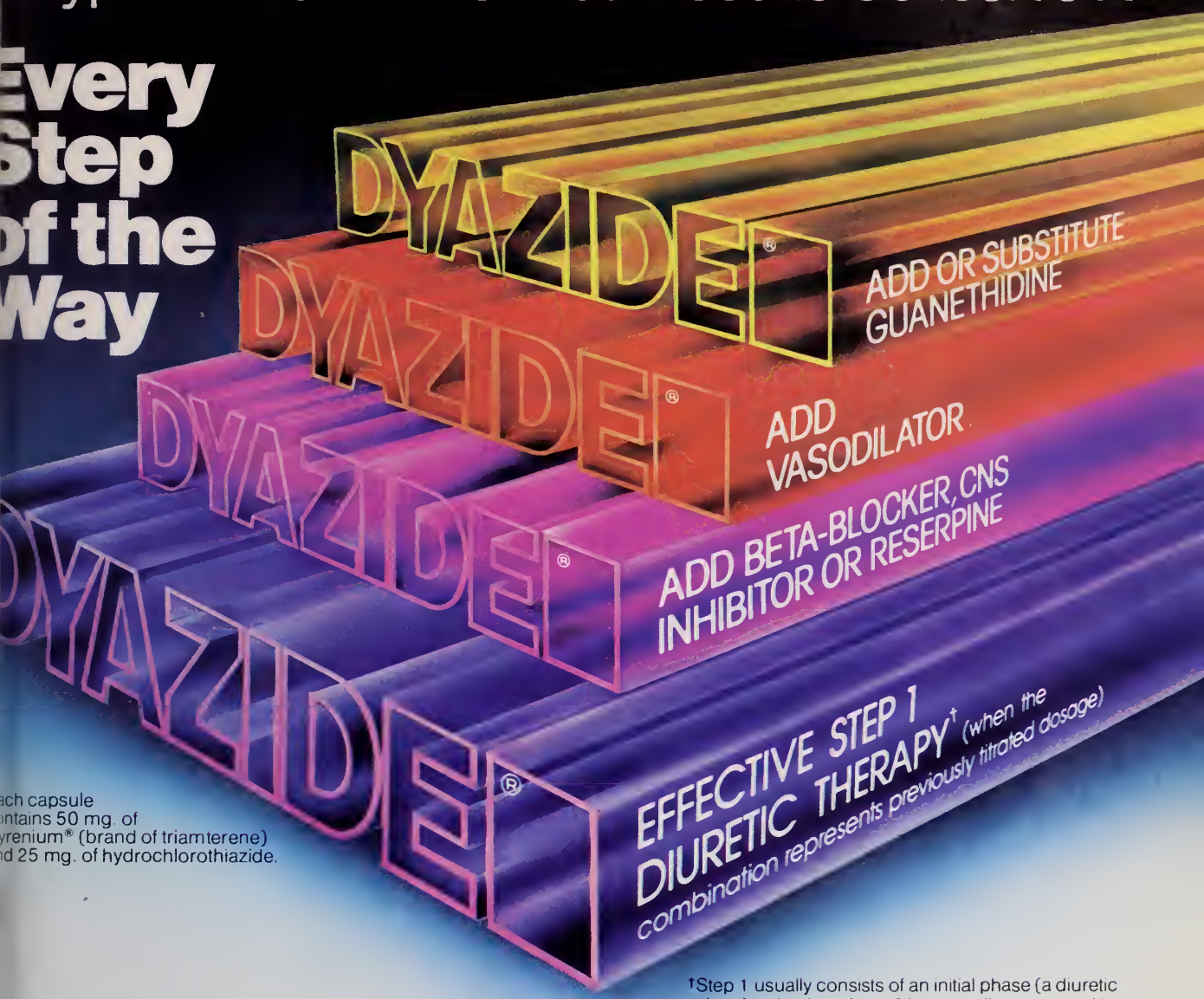

ach capsule
ontains 50 mg. of
yrenium® (brand of triamterene)
nd 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K+ supplement or K+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K+ supplement or K+-sparing agent).

Serum K+ and BUN should be checked periodically (see Warnings).

fore prescribing, see complete prescribing information SK&F Co. literature or *PDR*. The following is a brief nmary.

WARNING

This drug is not indicated for initial therapy of edema or ypertension. Edema or hypertension requires therapy trated to the individual. If this combination represents he dosage so determined, its use may be more conenient in patient management. Treatment of hypertenion and edema is not static, but must be reevaluated as conditions in each patient warrant.

ntraindications: Further use in anuria, progressive renal hepatic dysfunction, hyperkalemia. Pre-existing elevated um potassium. Hypersensitivity to either component or er sulfonamide-derived drugs.

rnings: Do not use potassium supplements, dietary or herwise, unless hypokalemia develops or dietary intake potassium is markedly impaired. If supplementary potasm is needed, potassium tablets should not be used. Hyperemia can occur, and has been associated with cardiac gularities. It is more likely in the severely ill, with urine lume less than one liter/day, the elderly and diabetics with spected or confirmed renal insufficiency. Periodically, um K+ levels should be determined. If hyperkalemia velops, substitute a thiazide alone, restrict K+ intake. **Assoted widened QRS complex or arrhythmia requires mpt additional therapy.** Thiazides cross the placental rrier and appear in cord blood. Use in pregnancy quires weighing anticipated benefits against possible hazds including fetal or neonatal jaundice, thrombocytopenia, ner adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other, serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and Dyazide should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth, anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions, nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis and of impotence have been reported with the use of 'Dyazide', although a causal relationship has not been established.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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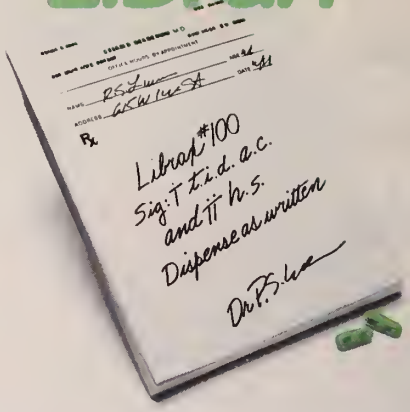
Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

ROCHE®

Roche Products Inc.
Manati, Puerto Rico 00701

rritable
BOWEL SYNDROME*

ist's concept of myoelectrical slow waves
the colon which seem to determine the
quency of colonic motor activity.

A visible difference in myoelectric rhythms of the colon

Studies reveal an increased frequency of 3-cycles-per-minute slow wave basic electrical activity in the colons of patients with IBS—a significant difference in basic colonic rhythm patterns from normal subjects.[1,2] These findings suggest a physiological basis for the spasm and hypermotility characteristic of IBS. The role of severe anxiety in triggering or aggravating such symptoms has long been recognized. Consequently, treatment should focus on both aspects of the problem.

Librax: A logical choice for patients with IBS

Logical, because the antimotility-antispasmodic actions of the Quarzan®(clidinium bromide/Roche) component of Librax can help to relieve the distressing abdominal symptoms associated with IBS.* Logical, because the antianxiety actions of the Librium® (chlordiazepoxide HCl/Roche) component can help to reduce the excessive anxiety that can contribute to IBS flare-ups.

References: 1. Sullivan MA, Cohen S, Snape WJ *N Engl J Med* 298:878-883, Apr 20, 1978
2. Snape WJ *et al* *Gastroenterology* 72: 383-387, Mar 1977.

Specify **Librax®** Adjunctive

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Antianxiety/Antisecretory/Antispasmodic

*Librax has been evaluated as possibly effective for this indication. Please see summary of prescribing information on facing page.

ROCHE®

for Knotts in the night

Prescribe new formula

Quinamm*

(quinine sulfate tablets)

each tablet contains quinine sulfate 260 mg

Specific therapy for painful night leg cramps

Merrell Dow

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Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes, or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

Quinamm™

(quinine sulfate tablets)

CAUTION Federal law prohibits dispensing without prescription

BRIEF SUMMARY

INDICATIONS AND USAGE

For the prevention and treatment of nocturnal recumbency leg muscle cramps

CONTRAINDICATIONS

Quinamm may cause fetal harm when administered to a pregnant woman. Congenital malformations in the human have been reported with the use of quinine, primarily with large doses (up to 30 g) for attempted abortion In about half of these reports the malformation was deafness related to auditory nerve hypoplasia Among the other abnormalities reported were limb anomalies, visceral defects, and visual changes In animal tests, teratogenic effects were found in rabbits and guinea pigs and were absent in mice, rats, dogs, and monkeys Quinamm is contraindicated in women who are or may become pregnant If this drug is used during pregnancy, or if the patient becomes pregnant while taking this drug, the patient should be apprised of the potential hazard to the fetus

Because of the quinine content, Quinamm is contraindicated in patients with known quinine hypersensitivity and in patients with glucose-6-phosphate dehydrogenase (G-6-PD) deficiency

Since thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients, a history of this occurrence associated with previous quinine ingestion contraindicates its further use Recovery usually occurs following withdrawal of the medication and appropriate therapy

This drug should not be used in patients with tinnitus or optic neuritis or in patients with a history of blackwater fever

WARNINGS

Repeated doses or overdosage of quinine in some individuals may precipitate a cluster of symptoms referred to as cinchonism Such symptoms, in the mildest form, include ringing in the ears, headache, nausea, and slightly disturbed vision, however, when medication is continued or after large single doses, symptoms also involve the gastrointestinal tract, the nervous and cardiovascular systems, and the skin

Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine Quinamm should be stopped immediately if evidence of hemolysis appears

If symptoms occur, drug should be discontinued and supportive measures instituted In case of overdosage, see OVERDOSAGE section of prescribing information

PRECAUTIONS

General

Quinamm should be discontinued if there is any evidence of hypersensitivity (See CONTRAINDICATIONS) Cutaneous flushing pruritus, skin rashes, fever, gastric distress, dyspnea, ringing in the ears, and visual impairment are the usual expressions of hypersensitivity, particularly if only small doses of quinine have been taken Extreme flushing of the skin accompanied by intense, generalized pruritus is the most common form Hemoglobinuria and asthma from quinine are rare types of idiosyncrasy

In patients with atrial fibrillation, the administration of quinine requires the same precautions as those for quinidine (See Drug Interactions)

Drug Interactions

Increased plasma levels of digoxin and digitoxin have been demonstrated in individuals after concomitant quinidine administration Because of possible similar effects from use of quinine, it is recommended that plasma levels for digoxin and digitoxin be determined for those individuals taking these drugs and Quinamm concomitantly

Concurrent use of aluminum-containing antacids may delay or decrease absorption of quinine

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants

The effects of neuromuscular blocking agents (particularly pancuronium, succinylcholine, and tubocurarine) may be potentiated with quinine and result in respiratory difficulties

Urinary alkalizers (such as acetazolamide and sodium bicarbonate) may increase quinine blood levels with potential for toxicity

Drug Laboratory Interactions

Quinine may produce an elevated value for urinary 17-ketogenic steroids when the Zimmerman method is used

Carcinogenesis, Mutagenesis, Impairment of Fertility

A study of quinine sulfate administered in drinking water (0 1%) to rats for periods up to 20 months showed no evidence of neoplastic changes

Mutation studies of quinine (dihydrochloride) in male and female mice gave negative results by the micronucleus test Intraperitoneal injections (0 5 mM kg) were given twice, 24 hours apart Direct *Salmonella typhimurium* tests were negative, when mammalian liver hemogenate was added, positive results were found

No information relating to the effect of quinine upon fertility in animal or in man has been found

Pregnancy

Category X See CONTRAINDICATIONS

Nonteratogenic Effects

Because quinine crosses the placenta in humans, the potential for fetal effects is present Stillbirths in mothers taking quinine have been reported in which no obvious cause for the fetal deaths was shown Quinine in toxic amounts has been associated with abortion Whether this action is always due to direct effect on the uterus is questionable

Nursing Mothers

Caution should be exercised when Quinamm is given to nursing women because quinine is excreted in breast milk (in small amounts)

ADVERSE REACTIONS

The following adverse reactions have been reported with Quinamm in thera or excessive dosage (Individual or multiple symptoms may represen chonism or hypersensitivity)

Hematologic acute hemolysis, thrombocytopenic purpura agranulocy hypoprothrombinemia

CNS visual disturbances, including blurred vision with scotomata, photopl diplopia diminished visual fields, and disturbed color vision, tinnitus, dea and vertigo, headache nausea vomiting fever, apprehension, restless confusion, and syncope

Dermatologic-allergic cutaneous rashes (urticarial the most frequent t allergic reaction, papular, or scarlatinal), pruritus flushing of the skin, swe occasional edema of the face

Respiratory asthmatic symptoms

Cardiovascular anginal symptoms

Gastrointestinal nausea and vomiting (may be CNS-related) epigastric p

DRUG ABUSE AND DEPENDENCE

Tolerance abuse, or dependence with Quinamm has not been reported

OVERDOSAGE

See prescribing information for a discussion on symptoms and treatm overdose

DOSAGE AND ADMINISTRATION

1 tablet upon retiring If needed 2 tablets may be taken nightly—1 followi evening meal and 1 upon retiring

After several consecutive nights in which recumbency leg cramps do not Quinamm may be discontinued in order to determine whether continued t is needed

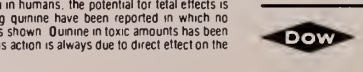
Product Information as of October, 1980

Licensor of Merrell™

MERRELL-NATIONAL LABORATORIES Inc
Cayey Puerto Rico 00633

Direct Medical Inquiries to

Merrell



MERRELL DOW PHARMACEUTICALS
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Cincinnati, OH 45215. U

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Medical Yellow Pages

RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

Energetic Family Practitioner needed to join busy group practice consisting of four physicians. Central Wisconsin town of 15,000 with drawing area of 25,000. Excellent salary first year with many fringe benefits. Full partnership next year. Send CV to Merrill Medical Associates, SC, 716 E 2nd St, Merrill, Wis 54452. 9-11/81

Experienced Emergency Physician sought for four-man group, Southeastern Wisconsin. Annual visits 24,000. Modern facility with full specialty back-up. Equal sharing shifts. Fee for service. 90 K per annum. Emergency experience desirable. ACLS. Send CV or call R J Krill, MD, 3801 Spring St, Racine, Wis 53405; ph 414/636-4011. 11-12/81

Oncologist needed to join the only two oncologists in the community working within a multispecialty group of 22 physicians at the Racine Medical Clinic. The Clinic is a progressive organization offering a competitive salary for the first 18 months with a full ownership thereafter and a full fringe benefit package. Contact R D Lacock, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis; ph 414/886-5000. 10 tfn/81

General Surgeon. Board eligible/certified to join primary care group of six family physicians. Well established, rural setting, preceptor University of Wisconsin, JCAH 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis 54615. 10 tfn/81

Neurologist, Allergist, Cardiac Surgeon, Nephrologist, Psychiatrist. Opportunities in small group private practice. Tertiary referral center with active teaching program and fully equipped hospital including advanced lab facilities, CT scanner, oncology program, cath lab, cardiac surgery, neurosurgery, dialysis, etc. Service area 300,000 plus. Unspoiled university city on Lake Superior offers outstanding recreational opportunities. Contact: J D Wojcik, MD, Chairman, Recruitment Committee, Marquette General Hospital, Marquette, Mich. 49855; ph 906/228-9449, ext. 434. 10-12/81

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095
pl-12/81

Family Practitioner to join 16-physician multispecialty group in North Central Wisconsin primarily to staff and direct satellite facility 27 miles from base clinic. Malpractice insurance provided. Compensation and corporate fringe benefits fully competitive. University affiliation. Combined drawing area 55,000 population. In year-round recreation area, excellent schools, and shopping. Send curriculum vitae and correspondence to Gerald C Larson, Assistant Administrator, W S Bump Medical Group, SC, 1020 Kabel Ave, Rhinelander, Wis 54501. 11/81

Medical Ophthalmologist wanted to join established, growing practice in beautiful Lake Tahoe-Reno, Nevada area. Excellent climate and year-round recreational facilities. Will consider full or part-time or retired physician. Contact Karen Grodowitz, MS, Executive Director, Reno Eye Clinic, 1530 E 6th St, Reno, Nev 89512; ph 702/329-1389. 10 tfn/81

Family Practitioners to work in community clinics near Madison, Wisconsin. Combination of a community office practice with privileges at major Madison hospitals. Family practitioner will join an already established internist to continue the growth of a medical practice, expand a small pediatric practice, and begin an obstetrical practice. Clinics are full service and have professional personnel support. Physicians have a guaranteed compensation package and an option to purchase the clinic from the community. Please send resume to T Arnfelt, Madison General Hospital, 202 South Park St, Madison, Wis 53715. 10-11/81

Internist wanted to join a 14-physician multispecialty group in one of northern Wisconsin's finest recreation areas. Modern 109-bed hospital. Excellent professional and personal opportunity. Contact Dr J Wiesner, Lakeland Medical Associates Ltd, Box 549, Woodruff, Wis 54568 or call 715/356-3292. 5tfn/81

Emergency Physicians. Full-time openings for ER physicians with group serving hospitals in Manitowoc, Sheboygan, Wisconsin Rapids, Shawano, Oconto Falls, and other cities. Excellent starting salaries, flexible schedules. Must be willing to relocate to area. Send CV to: Central States Emergency Physicians, PC, 1846 Hoffman St, Suite 101, Madison, Wis 53704 or ph 1/800-362-7366. 7-12/81

Surgeon with Thoracic general vascular training and Ophthalmologist to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

Physicians Exchange

continued

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties. *Family Practice, Hematology/Oncology, Neurology* and *Otolaryngology.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 7tfn/81

OB-GYN to join 16-physician multispecialty group in new facilities, including one OB-GYN, in North Central Wisconsin. Excellent Level II accredited Catholic hospital next door. Malpractice insurance provided. Compensation and corporate fringe benefits fully competitive. University affiliation. Drawing area 55,000 population. Junior college town of 15,000 in year-round recreation area, excellent schools, shopping, and air service. Send curriculum vitae and correspondence to Gerald C Larson, Assistant Administrator, W S Bump Medical Group, SC, 1020 Kabel Ave, Rhinelander, Wis 54501. 11/81

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Family Practice immediate opening. Join 22-physician multispecialty group in Appleton, Wisconsin. Excellent hospitals, guarantee plus incentive compensation. Complete benefit package. Medium-size community. Contact Art Schuetze, Administrator, Medical Arts Clinic, SC, 401 N Oneida St, Appleton, Wis 54911; ph 414/739-0171. 11-12/81; 1/82

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Call for appointment: 414/774-4400

Neurologist to join a three member neurology/neurosurgery group in Waukesha County. Negotiable salary with potential for full partnership after one year. Contact: James C Hanson, MD, Neurologic Associates of Waukesha Ltd, 1111 Delafield St, Waukesha, Wis 53186. p9-11/81

Physician wanted to perform light physicals on a full or part-time basis. Ideal job for retiring physician. Contact Mike Stough collect at 513/621-8728. 10 tfn/81

Internist with or without a subspecialty, wanted to join Milwaukee Internal Medicine Group. First-year salary negotiable. Opportunity to join corporation. Excellent fringe benefits and retirement plan. Contact: Administrator, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 11-12/81

Professional FP Locum Tenens available. Board certified family practice. Wide range of experience including OB and ER. Prefer 1-2 week periods. $1800 per week plus room and travel. Write 5695 Mary Lane, Excelsior, Minn 55331; ph 612/474-4372. 11-12/81; 1/82

Obstetrician-Gynecologist. Board certified or eligible to join 12-member group in progressive northwestern Wisconsin community of 8000. Modern, well-equipped hospital located adjacent to our facility. Close to Minneapolis, Eau Claire, and Duluth, the Rice Lake area offers excellent educational, religious, and community activities in addition to exceptional sports, hunting, fishing, and other recreational opportunities. For more detailed information regarding our group, send CV or call Dr Thomas A Fenger, Executive Officer, Indianhead Medical Group, 1020 Lakeshore Drive, Rice Lake, Wis 54868; ph 715/234-9031. 11/81

Emergency Physician-Wausau, Wisconsin. Fee-for-service corporation with excellent income and benefits. New facility with excellent backup of all specialties. Generous time off to enjoy this family and sportsman's paradise. Emergency Medicine or Family Practice residency or Emergency Medicine Board certified required. Send CV or call Fred Klemm, MD, 2404 Hawthorne Lane, Wausau, Wis 54401; ph 715/842-9373. p11-12/81/1-82

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Family Practice, Internal Medicine and Pediatric positions available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303; ph 414/494-5611. 9-12/81

Attractive Emergency Room Opportunity. Lake Geneva area. Day shifts. Guaranteed minimum. Contact William Lange at Lakeland Hospital. Phone 414/723-2960. 9tfn/81

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive, Madison, Wisconsin 53716
Phone: (608) 222-2927 *Licensed Employment Agency*

Family Practitioner to join a 50-physician multispecialty group with an 11-man Family Practice Department. Several challenging opportunities available in satellite practice. Initial guaranteed salary and excellent fringe benefits available. City of 50,000 on the Mississippi River. Outstanding place to live, work, and enjoy varied cultural and recreational opportunities. Contact: Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, Wis 54601; ph 608/782-9760. 11-12/81; 1/82

Orthopedic Surgeon to join an established two-man department in a multispecialty group located adjacent to an expanding medical center in Western Wisconsin. The community offers a wide variety of year-round cultural and recreational opportunities for the entire family. Our corporate organization offers a generous first-year guaranteed salary and production-incentive income thereafter. The fringe benefit package is all inclusive and most attractive. Contact Director of Professional Affairs, Skemp-Grandview-LaCrosse Clinic, Ltd, 815 S 10th St, La-Crosse, Wis 54601. 9-11/81

Two Family Practice Physicians sought to assume a fully operational practice in a community 30 miles north of Madison, Wisconsin. New clinic facility. Income guaranteed. Physician back-up available. Board certified or eligible preferred. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 5tfn/81

Family or General Practitioner wanted at small town clinic in NW Wisconsin within one hour of Duluth. Rural area offers fishing, boating, hunting, skiing. Fully equipped clinic and support staff provided. Salary plus benefits and/or net income split. Send resume to WH Erskine, NWMC, Box 86, Minong, WI 54859; or call 715/466-2201. 8tfn/81

Physician's Assistant seeks relocation. Have national-Wisconsin state certification. Experience in rural primary care and general surgery. Prefer small community or rural family practice in Southeastern Wisconsin. Resume and references upon request. Contact Dept 494 in care of the Journal. 9tfn/81

Fond du Lac—26 physician incorporated multispecialty group on the south shore of Lake Winnebago needs a fourth pediatrician. Guaranteed salary with full shareholder status available after one year. Send CV to Kirk A Veit, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 9tfn/81

Obstetrician-Gynecologist, Board certified or eligible, to join 13-physician multispecialty group in metropolitan Milwaukee. Community of 31,000 offers excellent cultural, educational, and recreational facilities. Guaranteed first-year salary plus incentive. Ownership and comprehensive fringe benefit program available after one year. Send CV or inquiries to: PO Box 97, Butler, Wis 53007. 7tfn/81

Family Practice. General Clinic—Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Internist with training in pulmonary disease needed to join a 22-physician multispecialty group in Appleton, Wis. Excellent hospitals, guarantee plus incentive compensation. Complete benefit package. Medium size community. Contact Art Schuetze, Administrator, Medical Arts Clinic, SC, 401 N Oneida St, Appleton, Wis 54911. Phone 414/739-0171. 9-11/81

Medical Facilities

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

For Sale: Eau Claire, well equipped and maintained medical office. Near downtown, on bus line; eleven hundred square feet; waiting room, private office, four examining rooms, laboratory. Ground floor, parking in rear. Rented four room and bath apartment above. General practitioner retiring after thirty years. Large patient following. Selling building and equipment. General practitioners needed. Contact: George E Wahl, MD, 616 E Grand Ave, Eau Claire, Wis 54701; ph 715/835-8038. 10tfn/81

Family Practice. Established, independent practice in equipped office. Small city in recreational area. Continued care of patients main interest. Contact: KL Haman, MD, 199 South Division, Waupaca, Wis 54981; ph 715/258-2707. 11tfn/81

Immediate solo practice available in Jefferson, Wisconsin, due to the recent death of Richard H Siedenburg, MD. Expandable building with three large lots available. Lease or purchase. Contact Miller Law Office, PO Box 417, Jefferson, Wisconsin 53549; ph 414/674-3345. g11tfn/81

Milwaukee Internal Medicine Group wishes to share its downtown or Bayside well-equipped office space with any medical specialty. Contact: Administrator at 414/271-6800. 11-12/81

Miscellaneous

Author's editor. Technical assistance for your manuscripts and medical writing. K M Lopate, Picas Unlimited, 235 N Eastmoor, Brookfield, Wis 53005; ph 414/786-3922. p11/81

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Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1981 through Aug 31, 1982.

WISCONSIN

DECEMBER 2-4, 1981: *Sports Medicine Conference Focus on Cross-Country Skiing,* Telemark Lodge, Cable. Sponsored by the Office of Continuing Medical Education of the University of Minnesota Medical School, with the University's School of Physical Education, Recreation, & School Health Education and Continuing Education and Extension. Approved 24 credit hours of PRA-AMA/ACCME; prescribed credit for the Minnesota Academy of Family Physicians; Continuing Education Units of the University of Minnesota; and Level 1 Nordic Certification accreditation of the United States Ski Coaches Association have been applied for. Info: Office of Continuing Education, University of Minnesota Medical School, Box 293 Mayo Memorial Bldg, 420 Delaware Street Southeast, Minneapolis, MN 55455; ph 612/373-8012. g11/81

DECEMBER 11-12, 1981: *Coronary Artery Disease—the View in 1981,* Wisconsin Center, Madison. Sponsored by University of Wisconsin, School of Medicine, Department of Medicine, Division of Cardiology and Department of Surgery, Division of Thoracic and Cardiovascular Surgery, and University of Wisconsin-Extension, Department of Continuing Medical Education. Approved 12 credit hours Category 1 of AMA-PRA; AOA Category 2-D, University of Wisconsin-Extension, Continuing Education Hours; AAFP credit applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

12th ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS

January 27-29, 1982 at The Pfister Hotel and Tower, Milwaukee, Wisconsin

The Department of Family Practice, The Medical College of Wisconsin, and Southeast Chapter of the Wisconsin Academy of Family Physicians.

This three-day course will cover topics in Diabetes, Cardiology, Obstetrics, Gynecology, Adolescent Medicine, and clinical updates in Rheumatology, Peripheral Vascular Disease and Pneumococcal Disease.

Accepted for 20 credit hours Category 1 AMA-PRA and AAFP.

Fee: $175. Course Director: Louis R Rosin, MD Associate Professor of Family Practice.

Info: Mrs Susanna Rechlitz, Conference Manager, Dept of Family Practice, Seton Tower, 2315 North Lake Dr, Milwaukee, Wis 53211. Phone: 414/297-0813.

DECEMBER 14, 1981: *DSM-III: Advanced Clinical Symposium,* Edgewater Hotel, Madison. Sponsored by Continuing Medical Education, University of Wisconsin-Extension; and Department of Psychiatry, School of Medicine, University of Wisconsin. Credit: AOA Category I, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JANUARY 18-20, 1982: *New Therapeutics II: The Results of Recent Advances in Medicine,* Telemark Lodge, Cable. Sponsored by University of Wisconsin School of Medicine and Department of Continuing Medical Education. Approved 14 credit hours of Category I of AMA/AAFP. Fee: $215. Info: Ann Bailey, CME, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2854.

JANUARY 27-29, 1982: *12th Annual Winter Refresher Course for Family Physicians,* at The Pfister Hotel and Tower, Milwaukee. Sponsored by Department of Family Practice, Medical College of Wisconsin, and the Southeast Chapter of the Wisconsin Academy of Family Physicians. Approved 20 credit hours of Category I of AMA-PRA and AAFP. Info: Mrs Susanna Rechlitz, Conference Manager, Dept of Family Practice, Seton Tower, 2315 N Lake Dr, Milwaukee, Wis 53211; ph 414/291-0813.

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings 1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
1992—Apr 23-25	

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

FEBRUARY 3-5, 1982: *Ninth Annual North Central Wisconsin Clinical Cancer Conference,* Telemark Lodge, Cable. Sponsored by Marshfield Clinic, Marshfield Medical Foundation, American Cancer Society, Wisconsin Division, Inc, and Minnesota Division, Inc. This program is designed to review medical problems related to cancer and their treatment. Approved 7¾ credit hours of Category I AMA-PRA; 7¾ credit hours WAFP. Fee: $50. Enrollment limited to first 100 registrants. Info: Office of Medical Education, 1000 North Oak, Marshfield, Wis 54449; ph 715/387-5207.

FEBRUARY 25-28, 1982: Wisconsin Psychiatric Association, Lake Lawn Lodge, Lake Delavan.

FEBRUARY 26-27, 1982: *Clinical Genetics for Primary Care Physicians,* Madison. Sponsored by Department of Medical Genetics, University of Wisconsin; and Continuing Medical Education, University of Wisconsin-Extension. Credit: AMA Category I, AAFP, AOA. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

FEBRUARY 27, 1982: Wisconsin Dermatological Society, UW Center for Health Sciences, Madison.

MARCH 25-26, 1982: *6th Annual Ophthalmology Current Concepts Seminar '82,* at Inn on the Park Hotel, Madison. Sponsored by University of Wisconsin, School of Medicine, Dept of Ophthalmology; and University of Wisconsin-Extension, Dept of Continuing Medical Education. Credit applied for Category I of AMA-PRA. Fee: $155. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

Medical/Surgical Update '82

TELEMARK LODGE CABLE, WISCONSIN

Wednesday, February 17 - Friday, February 19, 1982

Medical/Surgical Update '82 is designed primarily for general practitioners, family practitioners, general internists and general surgeons. This program focuses on numerous aspects in the fields of medicine and surgery. Various speakers will discuss techniques, problems, innovations and treatments relating to health care.

Registration fee: $125.00
Enrollment is limited to the first 100 registrants. Advanced registration is required; deadline is December 30, 1981.

This program is approved for 9½ hours of prescribed credit from the Wisconsin Academy of Family Practice. It is also approved for 9½ hours of CME Category I credit by the AMA.

A ski package is available for all participants and their families. This package includes a room at the lodge Wednesday and Thursday evenings, downhill and cross country skiing for three days, the use of Telemark's indoor pool, whirlpool and saunas and nightly entertainment.

Sponsors: Marshfield Clinic and Marshfield Medical Foundation

Further information concerning this seminar is available from Marshfield Clinic's office of Medical Education, 1000 N. Oak Ave., Marshfield, Wisc. 54449 or phone 715/387-5207.

STATE MEDICAL SOCIETY OF WISCONSIN
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OTHERS

DECEMBER 5-10, 1981 (California): American Academy of Dermatology, San Francisco Hilton, San Francisco. B W Claxton, CAE, Executive Director, 820 Davis St, Evanston, IL 60201.

DECEMBER 8-10, 1981 (Florida): *American Cancer Society National Conference-Gastrointestinal Cancer-1981,* Fontainebleau Hilton Hotel, Miami Beach, Fl. Approved 13 credit hours Category I of AMA-PRA and AAFP. Info: Nicholas G Bottiglieri, MD, American Cancer Society, National Conference-Gastrointestinal Cancer-1981, 777 Third Ave, New York, NY 10017.

JANUARY 20-22, 1982 (Michigan): *Hazardous Materials Emergency Medical Treatment* symposium at Michigan State University for physicians, nurses, EMTs, and other EMS personnel. Topics include pharmacology, toxicology, materials handling, and decontamination of, and medical treatment in the field and hospital for exposure to, organic solvents, corrosives, and pesticides. Other topics are transportation emergencies, agricultural chemical emergencies, and emergency medical response planning. Faculty is comprised of medical, government, academic, and industry authorities, including nationally recognized experts in EMS. Sponsored by American College of Emergency Physicians (Michigan Chapter), MSU Community Development, and MSU Center for Environmental Toxicology in cooperation with MSU Colleges of Human Medicine, Osteopathic Medicine, Nursing and MSU Lifelong Education Programs. Nineteen hours ACEP Category I credit applied for. EMT and Nurse CEUs applied for. Physician CME credits applied for. Contact Joan Alam, Michigan State University, 23 Kellogg Center, East Lansing, MI 48824; phone 517/353-7822.

JANUARY 21-26, 1982 (Louisiana): American Academy of Orthopaedic Surgeons, New Orleans. C V Heck, MD, Executive Director, 444 N Michigan Ave, Chicago, IL 60611.

FEBRUARY 12-21, 1982 (Tahiti): The medical specialties of French Polynesia invite all Wisconsin physicians to a Continuing Medical Education Program. Sponsored by the State Medical Society of Wisconsin. Info: State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701; ph 1-800/362-9080.

MARCH 1-2, 1982 (Michigan): *6th Annual Winter Pediatric Seminar,* Caribou Lodge, Powderhorn Ski Area, Bessemer, Michigan. Sponsored by Marshfield Clinic and Marshfield Medical Foundation. Approved 8 credit hours of Category I of AMA-PRA and AAFP. Fee: $60. Registration deadline, Feb 22, 1982. Info: Marshfield Clinic's Office of Medical Education, 1000 N Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.
g11-12/81; 1/82

MARCH 8-12, 1982 (Hawaii): Sports Medicine Postgraduate Course, Maui, Hawaii. Approved 25 credit hours of Category I AMA-PRA. Info: Bates Noble, MD, Course Director, Northwestern University Center for Sports Medicine, 303 East Chicago Ave, Chicago, IL 60611. g11/81

MAY 16-20, 1982 (Brazil): *The Fifth International Symposium on the Prevention and Detection of Cancer, San Paulo, Brazil.* Sponsored by Fundacao "Centro de Pesquisda de Oncologia" and The International Society for Preventive Oncology; Info: Medical Congress Coordinators Department, 1212 Avenue of the Americas, New York, NY 10036; ph 212/840-0110. g8-12/81; 1-4/82

AMA

DECEMBER 6-9, 1981: Interim AMA House of Delegates, Las Vegas, Nev.

FEBRUARY 25-28, 1982: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl. ■

"WATS" LINE FOR MEMBERS

The in-WATS (toll-free) line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

U.S. Postal Service STATEMENT OF OWNERSHIP, MANAGEMENT AND CIRCULATION of the *Wisconsin Medical Journal,* issued monthly.

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Total distribution	5647	5694
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TOTAL	5735	5800

I certify that the statements made by me are correct and complete.
/s/ MARY ANGELL
Managing Editor

Date of filing: Sept. 19, 1981
PS Form 3526, modified above for purposes of printing.

Nutritional Assessment Institute

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American Hospital Association Guide to the Health Care Field —1981

The 1981 edition of the *American Hospital Association Guide to the Health Care Field* has just been published by the AHA. Completely updated, based on the results of the 1980 Annual Survey of Hospitals, this edition of the *Guide* contains the most current and authoritative information available on health care institutions, on organizations and agencies in the health sector, and on national hospital statistical data.

The *Guide* is divided into three major parts. The first section lists, by geographic location, the names, addresses, and telephone numbers of the chief executive officers of some 7,000 hospitals in the United States and US-associated areas. Also provided are key data about selected services and facilities; classification by control, service, and length of stay; and selected statistical data on inpatients, newborns, expenses, and personnel. The second section lists other AHA institutional members and the names and affiliations of some 30,000 personal members of the Association. The third section lists the names, addresses, and telephone numbers of approximately 1800 international, national, and regional organizations, as well as US government agencies and state and provincial organizations and agencies. A detailed index provides easy access to the information provided in the book.

A valuable reference work for all those involved in the health care sector, the *American Hospital Association Guide to the Health Care Field*, AHA catalog no. 010081, is 542 pages in length. It is available from the AHA for $44 to AHA institutional and personal members, $55 prepaid for nonmembers.

Defined diets and childhood hyperactivity

National Institutes of Health Consensus Development Conference

January 13-15, 1982
at National Institutes of Health Masur Auditorium, Clinical Center (Building 10)

Bethesda, Maryland

Sponsored by the National Institute of Allergy and Infectious Diseases, cosponsored by the National Institute of Child Health and Human Development, and assisted by the Office for Medical Applications of Research.

Conclusions and recommendations concerning the effect of defined diets on childhood hyperactivity are not universally accepted nor agreed upon. The purpose of this conference is to review and evaluate data on this topic in an open national forum. The following questions will be addressed:

- What constitutes the hyperactivity syndrome in children? Is it a single disease or a cluster of diseases? Can it be graded or scaled in quantifiable variables of attention span, learning ability, social adjustment, etc, and by whom (teachers, parents, medical personnel)?
- What are the defined diets?
- Is there empirical evidence for an effect of these diets on hyperactivity (as defined)?
- Is there any physiologic explanation to support an effect of defined diets on hyperactivity?
- If defined diets are effective, how and under what circumstances should they be employed?
- What are the directions for research?

The format of the consensus conference calls for two days of presentation and discussion before a neutral panel of physicians, nutritionists, and appropriate lay people. On the third day the consensus statement, developed by the panel, is read and discussed.

For technical information contact: Dorothy D Sogn, MD, Special Assistant to the Director, Immunology, Allergic, and Immunologic Diseases Programs, National Institute of Allergy and Infectious Diseases, Building 31, Room 7A-50, Bethesda, Maryland 20205 (phone 301/496-1886).

For administrative information contact: Bettygail Fulcher, Prospect Associates, 11325 Seven Locks Road, Suite 221, Potomac, Maryland 20854 (phone 301/983-0535).

News You Can Use

By EARL THAYER, Secretary/BERNIE MARONEY, Assistant Secretary

APPENDECTOMY HEADLINE MISLEADING, WISPRO SAYS. The Wisconsin Professional Standards Review Organization (WisPRO) has voiced its objection to the *Milwaukee Sentinel* regarding an erroneous headline which accompanied a story on a WisPRO Appendectomy Study. In a letter to the *Sentinel,* WisPRO President John J Kief, MD, Rhinelander, wrote: "The presurgical diagnosis of appendicitis in a patient under emergency circumstances can be difficult. The 'news' is not that 14% normal appendices are being removed, but that so few normals were removed in our jurisdiction, (medical literature indicates a "20% normal" rate as an acceptable standard) and that the rate of removal can be further reduced 'by a small amount' without increasing undesirable outcomes; *eg,* rupture." Doctor Kief said it was ironic that the study's author, Donald Detmer, MD, UW Dept of Preventive Medicine, "took great pains not to dwell on the very positive results of the study in order to encourage physicians to achieve that last small area."

POSTAL SERVICE PUBLISHES BROCHURE ON MEDICAL QUACKERY. The Federal Postal Inspection Service has published a brochure on medical quackery which contains a postage-paid card for reporting cases of suspected medical fraud. The brochure: "Do You Believe in Magic" warns readers that "today's quacks are highly sophisticated salespeople who use widespread deceptive advertising to offer 'miracles' they can't produce." It stresses, "Discuss your medical problems with your family doctor." For a copy of the brochure, write: Chief Postal Inspector, Consumer Protection Program, Washington, DC 20260.

PATIENT ATTITUDE AND OPINION SURVEY AVAILABLE. Doctor, when was the last time you asked your patients for their opinions about how you may better meet their needs? The SMS Commission on Public Information has designed a brief questionnaire for physicians' offices which attempts to tap patient attitudes and opinions about a physician's practice. It includes questions about making appointments, office courtesy, doctor-patient communication, and billing procedures. Copies of the questionnaire are available in quantity at a cost of $3.00 per hundred plus $3.00 per order for postage and handling, from the SMS Communications Dept, PO Box 1109, Madison, Wisconsin 53701.

DEBATE CONTINUES ON PATIENT PACKAGE INSERT PROGRAM. The AMA last month called for rescission of regulations on patient package inserts (PPIs) and urged the Food and Drug Administration to develop "a cooperative program with the medical profession and other interested parties that will establish an effective means of providing important information about drugs to the individuals who use them." Testifying before the FDA, Alan Nelson, MD, a member of the AMA Board of Trustees, suggested exploration of the establishment of a private sector demonstration program to identify drugs for which patient information should be available, with physicians playing a key role. Earlier this year the AMA called for a moratorium on the Carter Administration's PPI regulations, which would have PPIs dispensed with ten of the most widely prescribed drugs or drug classes in a three-year pilot program. The program was put on hold by FDA Commissioner Arthur Hull Hayes Jr, MD, who said at the hearing that he favored providing drug information to patients but wanted new information on costs and benefits.

MEDICAL BOARD REAFFIRMS ITS POSITION ON DISPENSING MEDICATION IN SCHOOLS. The State Medical Examining Board has reaffirmed its position that school personnel who are not licensed nurses or physicians may only dispense medications to school children if "such services are performed under a physician's direction, supervision and inspection." The Board made its decision that the administration of medication fell within the practice of medicine in its review of a Madison Metropolitan School District policy on the subject. "At a minimum," the Board ruled, "this requires a physician to have directional contact initially by letter, or by telephone, with the person assigned to administer the medication and that the physician be willing to accept direct communications from the person administering the medication. The physician should state in writing either on the prescription or in the accompanying letter, the specific conditions under which contact should be made with the physician relative to the condition or reactions of the student receiving the medication." The physician should have parental consent to directly contact school personnel regarding administration of medication. Forms for complying with this law are in the process of being developed by the Wisconsin School Boards Association and other school authorities. The SMS Committee on School Health will review any proposed form and will distribute it to all SMS members upon completion. ■

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WISCONSIN MEDICAL JOURNAL

DECEMBER 1981

- Human exposures to pesticides
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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation. The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
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President's Page

ALBERT J MOTZEL JR, MD

Issues that may shape your future

IN EARLY NOVEMBER some 105 of your colleagues contributed a Friday and Saturday from their practices to participate in a Leadership Conference planned by the State Medical Society to acquaint them with those issues which have the greatest potential to affect the delivery of medical care during the next three to five years. Those in attendance included the officers and directors of the Society as well as commission and committee chairmen and officers or representatives of your county and specialty societies. It was not a passive meeting at which the majority listened to a few speakers patronizingly offer solutions to tomorrow's problems. Rather, it was an occasion that stimulated the participants to voice candid and frequently controversial opinions concerning the topics at hand. It was in this respect particularly that the conference was considered by all to be a great success.

A full report of the proceedings of the two days is being prepared for later publication in the Journal. A brief report of the conference appears elsewhere in this issue. The ultimate success of the conference largely depends upon the participants communicating the conference deliberations to their local county and specialty societies and to their colleagues. It would be especially valuable if those who attended the Leadership Conference were to lead such discussions and bring to the various groups the opinions and observations of those from other areas of the state or other specialties. Only when this type of interaction takes place throughout the Society and understanding, if not agreement, occurs among physicians in diverse locations and types of practice will we be able to increase our influence in either the political or business communities in Wisconsin. This is critical because it is from these sources that the healthcare industry will receive the greatest pressures during the first half of this decade. It is these pressures—primarily economic—that have the potential to result in rationing, new competitive configurations (HMOs, salaried company physicians, contractual arrangements) or new physician and patient constraints. Four topics, "Why doctors must do business with business and labor," "Health planning when the Feds pull out," "The role of organized medicine in public and private proposals to change reimbursement of physicians," and "Political effectiveness—how can we keep it?", as well as a luncheon speech by Kenneth Rentmeester, administrator of the Division of Health, Department of Health and Social Services, all addressed the need for physician involvement and the likelihood of real influence by organized medicine if it can unite behind a creative proposal with reasonable likelihood of creating responsibility for cost among providers and consumers of care. Both business and the Department of Health and Social Services ostensibly prefer this to themselves becoming further enmeshed in the intricacies of dispensing care.

If this is true, it behooves us now to continue these discussions and to produce a cohesive plan supported by the entire medical profession. This will require understanding and intelligent compromise on the part of some—*some* individuals, *some* geographic areas, and *some* specialties. The ultimate good for medicine and the recipients of medical care is what is at stake. Will we argue and bicker or will we make the effort to become leaders in the solution of the very difficult problems ahead? ■

Editorials WAYNE J BOULANGER, MD, *Editorial Director*

Official positions of the Society will be expressly identified as such; all others are views of the writer and not necessarily those of the Society.

Busybody business

EVERYBODY WANTS to play doctor. Now the Wisconsin Pharmacy Board with the support of the Wisconsin Pharmaceutical Association has joined the swelling crowd.

They have proposed a bill (SB 437) which allows pharmacists to administer as well as compound and dispense drugs. In addition, the bill authorizes pharmacists to "initiate" or "modify" drug therapy. That's pharmacese for "prescribe" or "change" the physician drug treatment. All under "guidelines" from the doctor, of course.

Not content with becoming physicians by statute, the pharmacists also want the Legislature to give the Pharmacy Board the right to license and discipline physicians who dispense.

Needless to say, the State Medical Society is opposing the bill. The red tape and added cost for dispensing licenses is cost containment in reverse. . .and it most seriously affects the rural doctors already in a bind to keep practices going in underserved areas. The Medical Examining Board already has responsibility for controlling and disciplining physicians who do not properly label the drugs they dispense. If the Medical Examining Board isn't getting the job done, perhaps it deserves a push. But, it would be irresponsible to dilute or give away the Board's authority.

Likewise, it borders on the irrational for pharmacists to ask to assume the legal liabilities inherent in prescribing and "changing" the doctor's prescription.

Perhaps all this is understandable when one realizes that the number of pharmacists has increased by about 1,000 in the last 10 years while the number of pharmacies has remained the same.

An old cliche suggests that lack of useful work makes for busybodies. That seems to be the case with the Pharmacy Board.

Obscene scene

PICTURE THE Wisconsin Legislature in its recent budget dilemma. Money is short and getting shorter. Medicaid recipients are increasing in number and age, both most costly. The unholy deed must be done: cut benefits.

The Governor bites the bullet. He cuts out chiropractic saving $1.8 million. He limits dental, prescriptions, and reduces outpatient psychiatric services to those provided directly by psychiatrists. Even though there are cries of anguish from recipients and providers alike, the Governor's actions were reasonable by any standard and they took some courage.

Now picture the legislative reaction to the Governor's budget cuts. The Joint Finance Committee restores chiropractic benefits, but totally eliminates outpatient psychiatric services except through 51.42 boards. Rationale: there has been some "fraud" in psychotherapy services! No matter that chiro adjustments don't aid mentally ill patients. No matter that laws have encouraged social psychotherapy rather than medical psychotherapy. No matter that the mentally ill will be forced into hospitals for care which T-19 will pay for at far more cost than the outpatient rate.

Now that's a bad scene. In fact, it's an obscene scene.

None for the road

THE HOLIDAY SEASON is in full swing, and will bring the usual round of cocktail parties and the usual opportunities to drink one too many. Especially vulnerable are those colleagues of ours who have a "problem" which they and their associates have tended to disregard. Perhaps this is as good a time as any to think about the "problem" and the solutions available to us.

There is perhaps no more unpleasant task for a chief-of-staff or hospital department chairman to face than taking action when a hospital staff member becomes an alcoholic. The soul-searching and foot-dragging which occur are endemic. After all, signs of impairment may be quite subtle, and competence has always been a matter of degree, besides. Who decides when the time to do something has been reached? Certainly it's not just the responsibility of the department chairman. Sometimes the first change is actually noticed by the nurse in charge of the second shift when she calls to tell the physician about the condition of one of his patients and detects slurred or inappropriate response. Sometimes the anesthesiologist notices a certain carelessness or clumsiness that wasn't there before. Sometimes the resident spots a low level of competence. But whoever becomes aware that the physician has

become impaired has a duty, pleasant or not, to see to it that appropriate, responsible people are notified.

No less an authority than our own president-elect, who has been in the forefront in dealing with the impaired physician at the Medical Society level, questions whether our physicians recognize the importance of early intervention in these situations, and reminds us that the services of the Society may be enlisted by simply calling 1-800-362-9080.

A good example of foot-dragging came to light recently. An impaired physician who had been a known alcoholic for three years in a hospital setting was finally curtailed in his activities. Eventually the matter was highlighted by the press and the question as to how the impairment went unheeded for so long was raised—and legitimately so. That impaired physician and his permissive colleagues would have been better served if the matter had been dealt with swiftly, incisively, and fairly years ago—and so too would the patients involved. —WJB

Editor's note: A report on the recent conference, *The Impaired Physician: Prevention, Intervention, and Rehabilitation,* appeared in the November issue of *WMJ.* Papers presented at this conference are being prepared for publication in a forthcoming issue.

Infant safety seats

SOME PEOPLE ARE surprised to find the State Medical Society of Wisconsin pressing for legislation (AB 600) to mandate the use of child passenger restraints. They shouldn't be. The State Society was among the first to support mandatory use of seat belts and a tough implied consent law to test for alcohol in drivers.

The issue is protection for infants who can't protect themselves. Auto accidents are the leading cause of death and serious injury for children beyond one month of age. Experience in other states shows that death can be cut in half where safety seats are required for infants.

Moreover, the educational value of required use of safety restraints as a young child may well spin off to young and old alike. A lifestyle set in youth may set a safety style for life.

While urging the law, the Society compliments its Auxiliary and related county medical societies who have contributed thousands of dollars and countless hours to making available infant car seats for loan use by mothers and babies as they leave the hospital.

All to the good. Now, the Legislature and the Governor can do their part with the passage and signing into law of AB 600.

Lies

IN JULY 1981, during a review session at a major Wisconsin insurance carrier, ten cases came under scrutiny. Each had been considered aberrant enough to merit denial of payment by the insurance company, and each denial had been challenged by the attending physician. The following four short case summaries taken from letters written to justify hospitalization and length of stay speak volumes:

Case 1: An internist writes: "The patient was admitted to the hospital for intravenous therapy and further diagnostic tests." The order sheet with the same physician's signature indicates general diet and no order for intravenous feedings.

Case 2: A physician writes: "The patient was admitted complaining of a severe cough with sore throat, weakness, dizziness and nausea as well as increased shortness of breath and hemoptysis." The record states, "This female patient was admitted with a chief complaint of sore throat, cold, headache and a cough. Discharge diagnosis is accute bronchitis." No mention is made in the chart of weakness, dizziness, nausea, shortness of breath or hemoptysis.

Case 3: A surgeon's letter states that the patient was confined to the hospital with severe back pain and also abdominal pain which was due to diverticulitis and duodenal ulcer. It further says he was very uncomfortable and his pain could not be treated as an outpatient. The same surgeon's admission note says: "This man comes in with upper gastric pain and nausea and back pain which has bothered him the most in the past six months. He comes in for a complete checkup."

Case 4: A gynecologist writes: "Because of bleeding her packing had to be left in for four days. It was removed on the fourth day and the patient was then discharged." The patient's dictated Discharge Summary states: "After the vaginal pack was removed on the first postoperative day there was no bleeding, and this patient was then discharged on the third postoperative day." His handwritten, signed progress note confirms.

In each instance the attending physician had little to gain personally from falsifying his reports except the gratitude of his patient, and while the interest in his patient's welfare was meritorious, in issuing a false statement he did himself and all of us a great deal of harm. It wasn't worth it.—WJB■

Economics I

As we begin another academic year, many of us are fascinated by the list of courses offered by the local community colleges and universities. As Osler said, "We are students to the end of our days," and we feel a strong desire to continue our pursuit of knowledge.

At the very same time, the publication *Office Call,* produced by Blue Cross and Blue Shield United of Wisconsin, announces an ambitious program to encourage ambulatory surgery. This effort has the approval of the Wisconsin Surgical Society, and nine procedures were selected with the concurrence of practicing physicians serving on the Blue Cross and Blue Shield United's Medical Policies Specialty Panels. They include certain breast biopsies, adenoidectomies, tubal ligations, hernia repairs, and diagnostic laparoscopies. Additional procedures include: dilatation and curettage (D&Cs), arthroscopies, carpal tunnels (median nerve decompressions), and tympanotomies/myringotomies (insertion of tubes into the ears for drainage).

Extrapolating on the financial savings of these procedures and confining their projections simply to the D&C procedure, the economists of Blue Cross-Blue Shield project that "if only an additional 10 percent of the procedures (D&Cs) were performed on an outpatient basis, the potential cost-savings would be approximately $173,000 for just the one procedure." The savings would increase proportionately as the percentage increased.

Using another example, the same publication states, "In 1980 the Plan paid for 6327 tubal ligations of which 4659 were performed on an inpatient basis. The difference in cost between an inpatient hospital setting and an outpatient setting for the surgical procedure is approximately $400. Therefore, the realistic cost-savings of 10 percent more of all such procedures performed on an outpatient basis would be $186,000." Further, "The expected cost-savings for all nine procedures based on a 10 percent increase in the performance of outpatient procedures is approximately $1.3 million."

Most of the hospitals in Wisconsin doing the vast bulk of these procedures are not-for-profit Wisconsin corporations. Most operate on the verge of financial catastrophe. Year in and year out they just manage to balance income against outgo; and in those years when they cannot make enough funds through their operations, they have fund drives and solicit donations. If at the end of a fiscal year the hospital has fallen behind, it appeals to the Rate Review Commission for an increase in room rates.

If the savings in 1981 are offset by increases in charges in 1982, is the notion of cost-saving a legitimate conclusion? Would not another interpretation be that for the people who absolutely must go into the hospital, their charges will be increased as much as is "saved" by outpatient surgery?

That brings us back to the collegiate curricula that always capture our attention. Maybe we should all sign up for the fall term in Economics I.

Raymond A McCormick, MD
Green Bay, Wisconsin ■

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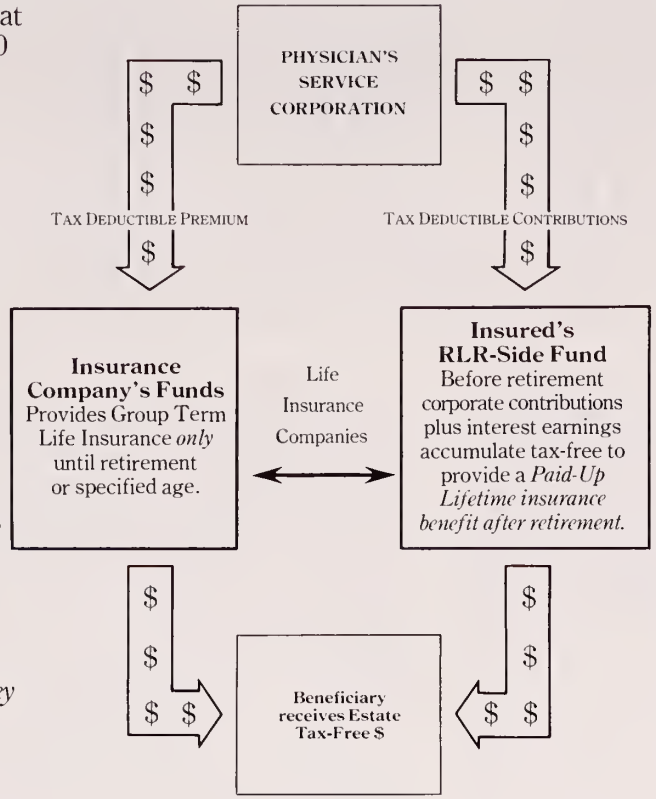

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Special

Human exposures to pesticides

A 1979-1980 report of the Wisconsin Division of Health

Harold B Weiss, MS, MPH, Madison, Wisconsin

ABSTRACT. *Surveillance and reporting of acute human health effects resulting from pesticide exposures is difficult from both a medical and administrative perspective. This report describes an evolving system of collecting and organizing pesticide incident reports in Wisconsin and presents information based on a decade of Worker's Compensation data and 1979-1980 pesticide incident reports from the Department of Agriculture, Trade and Consumer Protection. There is much room for improvement in both the quantity and quality of the data pertaining to acute pesticide exposure incidents.*

RECOGNIZING AND confirming human health effects from exposure to various pesticide formulas is difficult for many reasons. The patient may not be aware of the exposure. The physician may not recognize that a problem is caused by a pesticide. The laboratory may not be equipped to properly analyze blood and urine specimens for cholinesterase levels or metabolic derivatives of the parent compound. Specimen collection may be improper or delayed causing both false positive and false negative results. Persons are often exposed to multiple pesticides in combination with carrier solvents resulting in a confusing toxicological picture. Finally, people exposed to similar amounts of a particular chemical may react differently depending on an individual's general health, body stature, age, drug use, and smoking history, among other factors.

The above pertains only to recognizing and confirming that an exposure and effect have taken place. There are other factors that determine whether such an incident is reported in a logical and consistent manner through a surveillance network. The type of incident and where it occurs are important reporting determinants. Occupational exposure data (encompassing pesticide contact on the job during the manufacture, formulation and application of pesticides) may be partially determined from Worker's Compensation reports or from complaints directed to appropriate local, state, and federal agencies.

Data from accidental incidents (those taking place due to mixups, spills, and other haphazard events) and environmental exposures (similar to accidental exposures but usually involving lower concentrations often widely disseminated during "normal" pesticide use) may be derived from poison control centers, or a multitude of state, federal, and local agencies.

Despite the vagaries and scarcity in Wisconsin of previous years' accumulation of pesticide incident reports, useful summaries are available and are becoming more accessible from certain sources. A selected group of these sources and their recent data are presented below. It is hoped that with proper resources and development a more complete surveillance system can emerge from these and other repositories of pesticide incident data.

PESTICIDE EXPOSURE IN THE WORKPLACE

Worker's Compensation Data 1970-79

An important source of information on pesticide exposures can be culled from Worker's Compensation data derived from a data-base maintained by

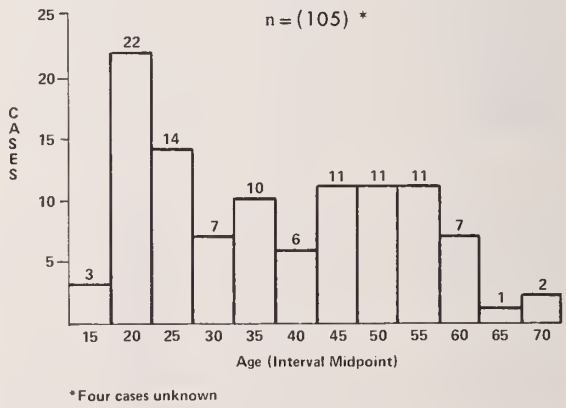

FIGURE 1—*Pesticide related Worker's Compensation reports by age group. Five-year intervals bracket the age range in which the specified number of incidents was reported over a ten-year period, 1970-1979.*

From the Environmental Epidemiology Section, Bureau of Community Health and Prevention, Division of Health, Wisconsin Department of Health and Social Services, Madison, Wisconsin. Reprint requests to: Harold B Weiss, MS, MPH, PO Box 309, Room 325, Madison, Wis 53701 (ph 608/267-7174). Copyright 1981 by the State Medical Society of Wisconsin.

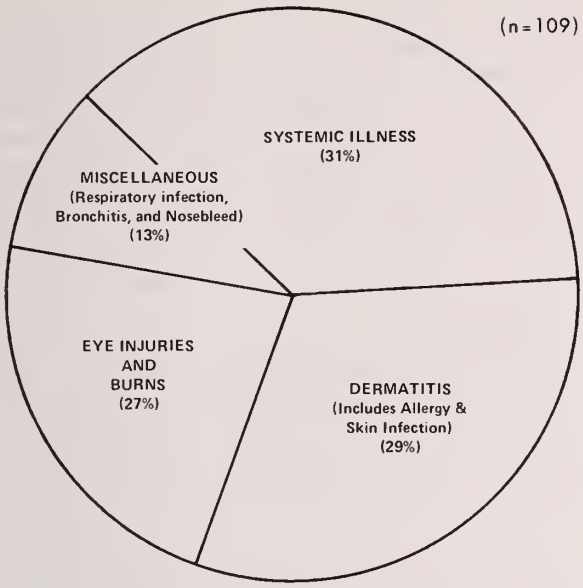

FIGURE 2—*Types of pesticide-related Worker's Compensation reports by type of associated illness.*

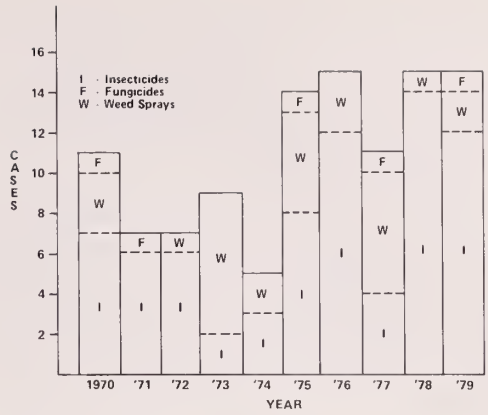

FIGURE 3—*Worker's Compensation reports by year and pesticide type.*

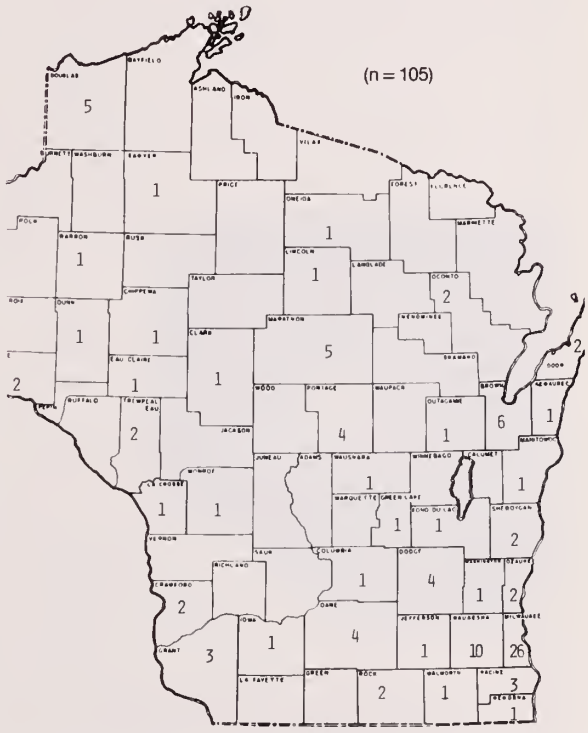

FIGURE 4—*Geographic distribution of cases of pesticide-related Worker's Compensation reports.*

the Department of Industry, Labor, and Human Relations. For the period 1970-79, over one-half million records were reviewed, and from those 109 cases were abstracted with an exposure code listed as *insecticides, weed sprays,* and *fungicides.*

Sixty-eight percent (74) of the cases involved exposure to insecticides, 28% (30) weed sprays, and 5% (5) fungicides. Eighty-one percent (88) of the cases were male.

The types of illnesses, by site, are listed in Figure 2. The systemic illnesses were analyzed separately to ascertain if, as expected, they are more severe. This was the case as evidenced by an average number of healing days off of 9.3 days for systemic injuries compared to an average of 3.6 days for the other categories of injuries ($p < .01$ for $t = 3.01$, 107 d.f.).

Figure 3 shows the number of cases reported each year by the class of pesticide involved in the incident. It is not known if the increase in numbers over the decade represents a larger work force being exposed or a higher rate of exposure.

Figure 4 and Table 1 show the geographic distribution and occupational classification for the study population. Based on population figures, as expected, Milwaukee has the most cases. This emphasizes the often overlooked evidence that reported pesticide exposure incidents take place frequently in urban environments. Many reported cases were not well classified by occupation (24 unknown "laborers"). It is notable, however, that many of the classified cases occurred in occupations not normally associated with pesticide use.

The severity of the exposure, as measured by the number of healing days per case, varied widely. The mean, was 5.3 days (Standard Deviation = 9.0) with a range of 0 to 45 days. A plot of the variables healing days by age did not reveal any significant correlation.

One hundred nine reported cases over a ten-year period of pesticide related Worker's Compensation reports have been presented. However, these 109 reported cases do not measure the magnitude of actual cases since many go unreported. The National Institute for Occupational Safety and Health (NIOSH) for example, using a survey involving personal and physician interviews, reported that only 11% of all the occupational illneses they found showed up on *either* OSHA reports or Worker's Compensation claims.[1] It is not known quantitative-

ly what the magnitude of under-reporting is for the particular category of "pesticide exposures," but if it is similar for all occupational illnesses, and in light of the aforementioned difficulties in recognition of pesticide-related morbidity, the under-reporting must be substantial.

In addition to under-reporting, the accuracy of reporting must also be kept in mind. Worker's Compensation data are not verified by an independent reviewer. The data are coded directly from compensation application claims submitted by the complainant or their representative. These data include claims that may have led to compensation and some that have not.

PESTICIDE INCIDENT REPORTS

Department of Agriculture, Trade, and Consumer Protection (DATCP)

The Plant Industry Division of the DATCP has a Pesticide Protection Section whose responsibilities include investigation and enforcement of cases of pesticide misuse. Any case coming to its attention is entered manually onto a Pesticide Incident report, revised in May 1979. For all of 1979, under the three categories of: (1) Drift, overspray, careless use and use of 2, 4, 5,-T, (2) improper storage, and (3) use contrary to label, 115 reports were filed, 10 of which concerned alleged human health effects from pesticide exposure. In 1980, 109 reports were filed of which 31 involved alleged human health effects. It should be noted that review of these records was accomplished manually and was dependent on abstracting only the data listed on the front page of the pesticide investigation form. Because these forms are used primarily for enforcement purposes and not health follow-up, the reports sometimes had incomplete information (blanks) and usually contained only subjective descriptions of symptoms by lay personnel or the exposed person themselves. Undoubtedly, cases of pesticide exposure with subjective health complaints were not included in the system due to reporting and recording deficiencies. On the other hand, there was rarely documentation by independent medical judgment as to the probability of a causal relationship between the alleged pesticide exposures and subjective health complaints. These data limitations must be kept in mind.

In 1979 six of the ten reports occurred in Dane County; all of the other four were reported from Portage County. In 1980 the reports were more scattered with Dane and Ashland counties reporting five incidents, followed by Milwaukee (three), Marathon, Waukesha, Wood, (two each), and single reports from 12 other counties (mostly in the southern part of the state).

Combining the 1979 and 1980 reports: Sixteen incidents involved use of an organophosphate insecticide and seven involved a carbamate compound. The cases occurred around the growing season with two events early in January and March, six in May and June, eight in July, 13 in August and one in September. About half of these health-related reports involved aerial application and associated off-target drift or misapplication. Headache and nausea were the most prevalent symptoms reported in association with the exposures, with a large number of reports involving mucous membrane irritation. Without complete follow-up of the cases, it is difficult to precisely delineate the severity of these illnesses, although 13 of 41 of the incidents resulted in a physician visit.

Insecticides (which are generally the most acutely toxic compounds), followed by herbicides, were responsible for most health related complaints.

It is important to note that notification of DATCP was often delayed by many days to the extent of seriously jeopardizing the usefulness of any enforcement related action and investigation (about one-half were delayed by four days or more). This delay, if combined with failure of the complainant to seek medical attention, may be crucial in establishing the validity of a complaint. On the basis of these reports, efforts should be directed to ensure both prompt DATCP notification and medical follow-up, if necessary.

PESTICIDE REPORTS—Poison Centers

Perhaps the single most important source of reports on pesticide-related poisonings could be the

TABLE 1—*A listing of occupational classifications for pesticide-related Worker's Compensation reports, Wisconsin, 1970-1979*

OCCUPATIONAL CLASSIFICATION	NO. OF CASES
Laborers (unknown)	24
Farm laborers and farmers	12
Mechanics and repairmen (miscellaneous)	8
Managers	8
Gardeners	7
Cleaners and janitors	7
Machine operators	7
Secretaries and typists	4
Food service workers	3
Warehousemen	3
Law enforcement personnel	3
Road machine operators	3

One or two cases were reported under the following classifications: pilot, inspector, sales clerk, retail clerk, cashier, foreman, auto mechanic, heavy equipment mechanic, plumber, stationary engineer, telephone installer, surveyor, manufacturing inspector, freight handler, nurse, housekeeper, and not classified.

two regional and three satellite National Poison Center Network affiliated poison centers. It has been estimated by the author (by comparison with Michigan's poison center data), that well over 300 detailed case reports a year would be detected from this source. However, the resources to record, abstract, and report this data have not been available to all centers. Limited data from 1981 will be reviewed in the upcoming year.

CONCLUSION. This report has described the problems involved in recognizing, confirming and reporting human pesticide exposure incidents in Wisconsin. It also has presented summary data from two available sources as well as describing the current data procurement efforts that are underway by the Wisconsin Division of Health in cooperation with other organizations.

None of the data summaries should be interpreted as representative of the nature and magnitude of human exposure to all pesticides in the state. Both the quantity and quality of the data leaves much to be desired from a public health and public policy oriented perspective. Newly begun initiatives should improve the development of a reporting network over the next few years. At best, however, if properly recorded and interpreted, pesticide exposure reports should be viewed as reflecting only a proportion of actual exposures and illnesses related to the use of chemical pesticides on the job, in agriculture, and in and around the home.

ACKNOWLEDGMENTS: The author wishes to acknowledge the assistance of the Wisconsin Department of Industry, Labor, and Human Relations and Department of Agriculture, Trade and Consumer Protection (DATCP) in procuring the records used in this paper. Individuals providing valuable assistance and manuscript review included Mr Larry Hanrahan, Henry Anderson, MD, Mr John Secora of the Division of Health, OR Ehart and James Enright of the Department of Agriculture, Trade and Consumer Protection, and John Brynes of the Department of Industry, Labor, and Human Relations. Thanks for preparation of the manuscript goes to Linda Holzbauer of the Bureau of Community Health and Prevention, Division of Health.

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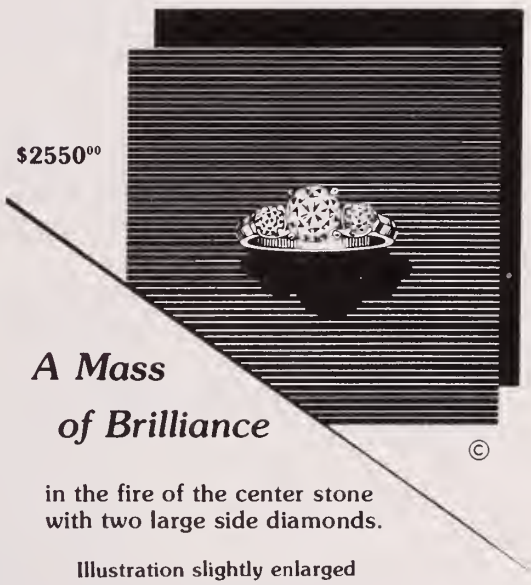
Physician placement directories published

Physicians and medical facilities now have help from the American Medical Association in filling their placement needs. The spring quarterly issues of both *Physician Placement Register* and *Opportunity Placement Register* are now available through the AMA's Physicians' Placement Service.

The Registers, one listing available physicians and the other current vacancies, are cross-indexed by medical specialty, type of practice setting, state, and size of community. Also available are separate listings of part-time and *locum tenens* positions and available physicians and a register of overseas opportunities.

The Physicians' Placement Service was established in 1944, and serves as a national resource, crossing both specialty and geographic lines.

There is a one-year registration fee for physicians of $35. AMA members receive a $10.00 discount. Hospitals and other medical facilities are charged an annual registration fee of $95. To receive a free copy of either Register, write to Physicians' Placement Service, American Medical Association, 535 N Dearborn Street, Chicago, IL 60610; or contact Michael P Muckian (312) 751-6594.



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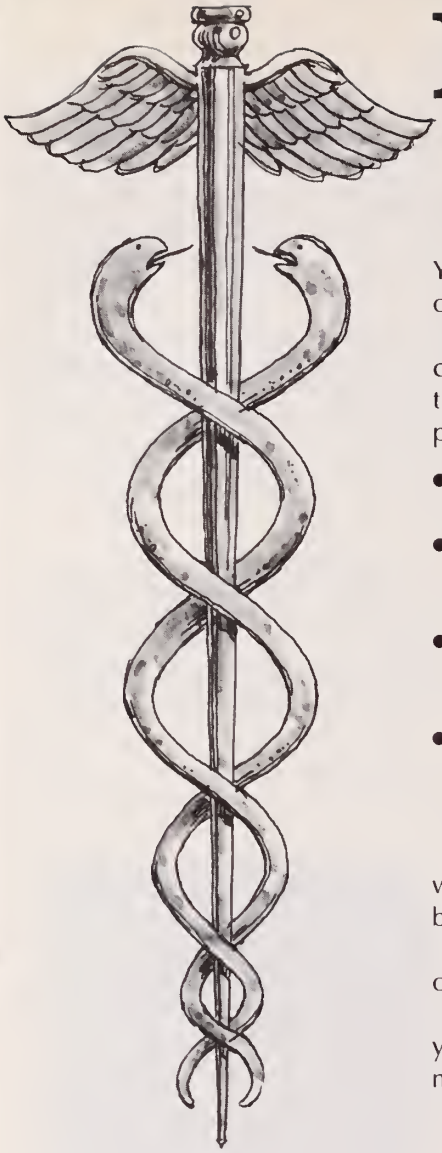

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Special

Diagnosing occupationally-induced diseases

Vernon N Dodson, MD, Madison; **Larry A Lindesmith, MD**, La Crosse; **Edward P Horvath Jr, MD, MPH**, Marshfield; **Carl Zenz, MD, ScD**, West Allis; and **Melvin S Blumenthal, MD**, Monroe, Wisconsin

IT IS ESTIMATED that between 4% and 15% of diseases encountered by a practicing physician are caused by the occupational environment or are naturally occurring diseases aggravated by occupational circumstances. If such statistics are applied to the number of patients seen by physicians, it would suggest that there are a larger number of occupationally-induced medical problems than are reported by physicians each year. The missed condition could better be diagnosed by increasing awareness of the large number of undiagnosed medical problems, developing a more adequate data base, especially an occupational medical history, and acquiring more information about the diseases of people at their work places.

The most common error made by the clinician who attempts to diagnose an occupational disease is to relate an ill-defined medical problem to a work environment about which no environmental information is available. More correctly, the first step should be to make a diagnosis of the disease or observe the symptoms, signs, and abnormal laboratory parameters. As much as possible this evaluation should be quantitative, both for symptoms and signs and for the laboratory data. The second step is to obtain quantitative information about the work environment (such as opportunity for exposure, the materials used, and environmental air measurements taken by the company, a governmental agency, or insurance carrier, etc). This step often requires obtaining material-safety data sheets from the employer, eliciting the employer's help in determining just what exposures really occur to the patient, investigating trade names as possible toxic substances through the use of the Poisondex at the local poison control center, and often writing or calling manufacturers. Finally, experience and published reports in the world's literature allow the investigation of any possible relationships between the medical problem and the occupational environmental circumstances.

The occupational history plays an important role in fully investigating the possibilities of relationship between disease or symptom complex and the work environment. At the same time other environmental exposures outside of the workplace, such as those experienced in hobbies, sports, and the home, also need to be considered. The State Medical Society of Wisconsin's Committee on Environmental and Occupational Health suggests consideration of the accompanying occupational history as a guideline to help the practicing physician in acquiring the appropriate occupational medical data base. This sample format is provided on pages 00-00. This is a suggested form that can be adapted to meet clinical needs. It has been designed so that the patient may complete the form, and the physician should review the form with the patient to clarify issues and avoid incompleteness by helping the patient to understand parts of the form if necessary. It is hoped that this form will serve as a helpful guide in diagnosing occupationally-induced diseases.

Approved for publication by the Executive Committee of the SMS Board of Directors, September 1981. Doctors Dodson, Lindesmith, Horvath, Zenz, and Blumenthal are members of the Environmental and Occupational Health Committee of the State Medical Society of Wisconsin. Doctor Dodson is Professor of Medicine and Professor of Preventive Medicine and Director of the Occupational-Environmental Medicine and Toxicology Section at the Center for Health Sciences, University of Wisconsin-Madison (504 Walnut St, Madison, Wis 53706); Doctor Lindesmith is a member of the Occupational Health and Medicine Section and Chief of the Pulmonary Physiology Section, Gundersen Clinic, Ltd (1836 South Ave, La Crosse, Wis 54601); Doctor Horvath is Chief of the Department of Occupational Medicine, Marshfield Clinic (1000 North Oak Ave, Marshfield, Wis 54449); Doctor Zenz is Clinical Professor of Preventive Medicine, University of Wisconsin-Milwaukee, and in private practice in Occupational Medicine (2418 Root River Pkwy, West Allis, Wis 53227); and Doctor Blumenthal is a member of the Department of Internal Medicine, Monroe Clinic (1515 - 10th St, Monroe, Wis 53566). Reprints available to SMS members as a membership benefit and to others at a cost of $3.00 payable in advance to: Wisconsin Medical Journal, State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701. Copyright 1981 by the State Medical Society of Wisconsin.

SUGGESTED OCCUPATIONAL EXPOSURE HISTORY
Part I

Please answer the following questions. Begin with your present job and list all jobs or military service you have held in order of date whether full or part time.

TODAY'S DATE NAME SOCIAL SECURITY NUMBER JOB CLASSIFICATION(S)	List potential hazards exposed to: (examples)				Work related illnesses or injuries	
	Physical	Chemical	Biological	Psychological		
	Noise Radiation Vibration Electrical shock Temperature extremes Repetitive motion Heavy lifting	Mercury Lead Dust Gases Fumes Acids Solvents Caustics	Viruses Bacteria Parasites Fungus Animal bites Etc	Boredom Work shift fatigue Risk of falling Risk of being buried Repetition	YES	NO
COMPANY NAME CITY, STATE JOB TITLE FROM: TO: AVERAGE HR/WK	HAZARDS: COMMENTS:					
COMPANY NAME CITY, STATE JOB TITLE FROM: TO: AVERAGE HR/WK	HAZARDS: COMMENTS:					
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COMPANY NAME CITY, STATE JOB TITLE FROM: TO: AVERAGE HR/WK	HAZARDS: COMMENTS:					

SUGGESTED OCCUPATIONAL EXPOSURE HISTORY
Part II

SECONDARY WORK (examples) Firefighting, Civil defense, Farming, Gardening, Civic activities, Etc	List potential hazards exposed to: (examples)				Work related illnesses or injuries	
	Physical	Chemical	Biological	Psychological	YES	NO
	Noise, Radiation, Vibration, Electrical shock, Temperature extremes, Etc	Mercury, Lead, Dust, Gases, Fumes, Acids, Solvents, Caustics	Viruses, Bacteria, Parasites, Fungus, Animal bites, Etc	Boredom, Work shift fatigue, Risk of falling, Risk of being buried, Repetition, Etc		
ORGANIZATION CITY, STATE JOB TITLE FROM: TO: AVERAGE HR/WK	HAZARDS: COMMENTS:					
ORGANIZATION CITY, STATE JOB TITLE FROM: TO: AVERAGE HR/WK	HAZARDS: COMMENTS:					
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HOBBIES & ACTIVE SPORTS						
ACTIVITY CITY, STATE FROM: TO: AVERAGE HR/WK	HAZARDS: COMMENTS:					
ACTIVITY CITY, STATE FROM: TO: AVERAGE HR/WK	COMMENTS:					

Some chemicals have effects on the reproductive system. Have you or your present or former spouse had any problems with reproduction? If so, please indicate circumstances (e.g., stillborn, deformed, miscarriage, infertility).

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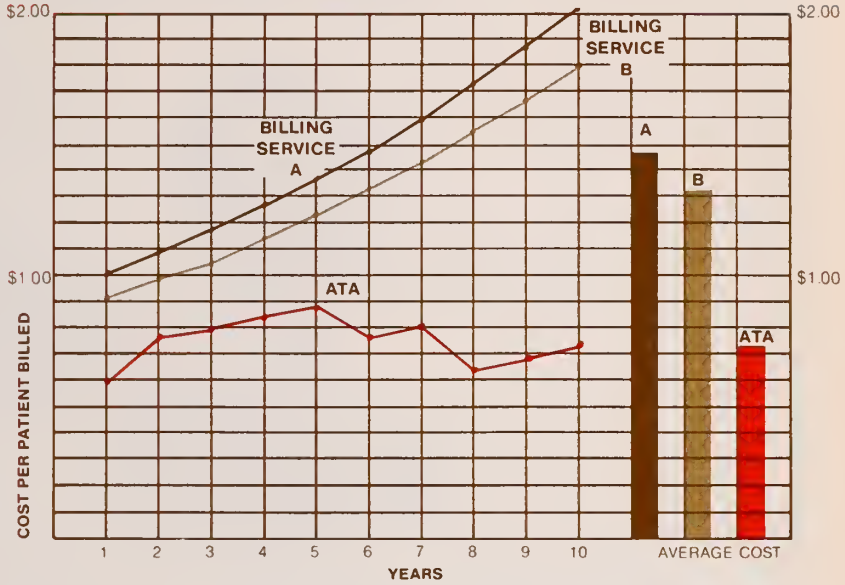

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Appendicitis . . .

Adolf Gundersen, MD, La Crosse, Wisconsin

EDITORIAL COMMENT. *I have been asked by Dr Charles H Miller, III, one of the surgeons of the Gundersen Clinic of La Crosse, Wisconsin, to translate from Norwegian to English an article written by my father, Dr Adolf Gundersen, also of La Crosse, Wisconsin, on appendicitis. This article was delivered to the Norwegian Medical Society in 1899. As you know, it was during this time that surgical treatment of appendicitis was being recognized in this country. There was considerable discussion regarding what treatment to use, either surgical or medical treatment. You also are aware of the anesthetic problem which was in the early stages of development. Chloroform or ether were used making relaxation of the abdomen very difficult to obtain. Of course, there were no medicines such as sulfonamides or penicillins.*

I had the privilege of working with him for many years. He was far advanced in many surgical fields such as the treatment of ulcers for which he did early gastric resection, realizing that duodenal ulcers were not corrected by gastroenterostomy. Besides this, he was one of a few early surgeons who believed that a cholecystectomy for gallbladder disease was important. Cholecystostomy was very seldom performed by him. He also was one of the first to recognize ectopic pregnancy and reported several cases to the Wisconsin Medical Society early in the century. After having worked with him for many years, I believe he was one of the most technically able surgeons I encountered either in this country or on my travels in Switzerland and France.

He was under the influence of Dr Hugh Young of Baltimore and wrote a paper on perineal prostatectomy. He wrote other papers on spinal anesthesia, and one on lung abscesses.

Sigurd B Gundersen Sr, MD

In the period from the first of January, 1894, until June of this year, 1899, Doctor Christen Christensen, Doctor Edward Evans, and myself performed 67 operations for appendicitis and peritonitis. Before this time we had so few completed medical histories that I have not included these cases here. With a few exceptions, all the operations included were performed at the Catholic hospital here in La Crosse. Eighteen were performed by Doctor Christensen, 19 by Doctor Evans and 30 by myself. The 67 cases to be reported here are as follows:

1. Twenty-six were operated on between attacks.
2. Five were done during an attack before the appendix ruptured.
3. Thirty were done during an attack after rupture of appendix with localized peritonitis.
4. In six cases generalized peritonitis had already set in.

In the first three groups, 61 cases, all patients were cured. Of the six with generalized peritonitis in Group 4, four died while two were cured. Viewed as a whole, there were 67 operations for appendicitis with four deaths, a mortality rate of about 6%. A large majority of these patients were serious cases, over half (36 cases) having a ruptured appendix with abscesses. In the other 31 cases, 27 had had several attacks, two were operated on because of pain due to previous adhesions (No. 7 and No. 31).

Of the first two groups, all 31 were operated on before rupture of the appendix and abscess formation, all are cured and, as far as I have been able to discover, all are able to take care of their daily work. One has since died of a bleeding duodenal ulcer; at autopsy, there was no trace of the appendix's previous location and no adhesions from the operation. Among these 31 cases, none has developed ventral hernias. Two of these cases have not been followed. All are pain-free.

The operative technique we followed was the usual one: The incision was made in the right linea semilunaris. After opening the peritoneum, packing was carefully placed around the infected area using sterile gauze compresses in order to localize and prevent leakage of pus into the peritoneal cavity. Following this, exploration for the appendix was done which was sometimes very difficult, often due to adhesions and varied position. The appendix follows all the cecum's movements and as a rule has no mesocecum to control its movements. Thus one may find the appendix—in any case its distal end—located practically anywhere in the abdomen; for example, in the left ileac fossa as in No. 16 and No. 54, in the pelvis as in No. 44 or below the liver as in No. 55 and No. 56. To begin the search, one should take the tinea of the colon and follow it down until it goes over into the appendix. We have frequently found the appendix 1) pointing down and into the pelvis, occasionally hanging over the pelvic brim, 2) turned upward and inward toward the cardia, often covered with small bowel, 3) lying laterally to the cecum and ascending colon, stretching over the right kidney and 4) not infrequently behind the cecum, and 5) close against the cecum without any peritoneum of its own case as in

No. 58. If an abscess occurs, it will in that case be extra-peritoneal and could be opened in the lumbar region as in No. 23 and No. 32, although the appendix cannot be removed then. It is easiest to find and remove the appendix when it lies in front of the cecum extending upward.

When one has found the appendix and loosened the adhesions, it is brought out of the wound with the cecum. The appendiceal mesentery is tied. Cutting around the appendix about 2 cm from the base through the peritoneum loosens the peritoneum which is folded up like a shirt cuff toward the cecum. The appendix is ligated at the base with catgut ligation and clipped off. The stump of the appendix is cleaned and its mucosa cauterized with carbolic acid. The peritoneal cuff is pulled down over which is thereupon implanted in the cecum with a purse string suture of catgut or pure silk. The cecum is now replaced in the peritoneal cavity and it is made certain that all adhesions in the area are divided or the pseudomembranes severed. It is especially important to loosen or tie off the omentum if it is adherent to the appendix. The abdomen is closed in layers using chromic catgut or kangaroo tendon suture material, and it is very important to suture the fascia carefully together. The skin is closed with silkworm gut, sometimes subcutaneously. Occasionally three to four silkworm sutures are used as tension sutures through the fascia. Twelve to 24 hours after the operation is complete, laxatives should be given, calomel 0.06 every hour or magnesium sulfate 1 tsp each hour followed by water enemas.

The convalescence has usually been easy, except for patient No. 66 who had difficulty with distention the day after the operation in spite of the fact he passed gas and had some bowel movements. He was also very nauseated and had urinary retention which required catheterization for one week. Pulse rate remained about 120, temperature was normal. His condition improved slowly. The wound was opened the third day but was closed again as normal conditions were found. He was a rather nervous patient who had suffered an attack of gastritis and dilatation of the stomach. The anesthetics used were first chloroform and then ether, and the patient took both very badly. He is now completely recovered. It is possible that this patient had an acute dilatation of the stomach following the anesthetic as in a recent case described by Doctor Fenger where death resulted.

The third and fourth groups include the more advanced pathology of appendicitis, where perforation with local or universal peritonitis occurred. There is a total of 36 patients of which 30 had localized abscesses and six had generalized peritonitis. Of the localized cases several had spread over the entire lower part of the abdomen; and the diagnosis before the operation was generalized peritonitis, but it turned out to be localized peritonitis with appendicitis restricted from spreading upwards by the transverse colon and the large omentum (Nos. 16, 25, 29, 54). They are all recovered, although recuperation lasted a long time, especially in the cases where the appendix was not removed and adhesions were present. This was the case in No. 16, while complete operation with removal of the appendix was done in No. 14. A few patients were so terribly ill during the operation that anesthesia could not be extended. Moreover, in a few of the suppurative cases, removal of the appendix seemed impossible, since it lies covered by the loops of the small intestine and the adhesions have existed for so many years they can only be loosened with great difficulty. Several outstanding physicians such as Mikulicz et al advocate just opening of the abscess site. Most American physicians such as Deaver, Murphy, and Bernays, among others, urgently advise removal of the appendix if it is at all possible. In the past few years we have worked hard trying to find the appendix, even in the suppurative cases, and remove it, since the operation can only be called complete when this is successful.

The operative technique is that described above; however, the incision is often made over the place where the tumor is most prominent in the hope that pus can be drained without opening the general peritoneal cavity. It the cavity is nonetheless opened first, one must be doubly careful in protecting the rest of the abdomen with damp gauze compresses. Only after this is done does one begin to loosen the adhesions. When one has gotten to the abscess cavity and there is pus present, this is dried away rapidly and thoroughly. The operative field is washed out with normal salt solution, the nearest compresses are replaced by clean ones, and one continues to divide adhesions until the appendix is isolated and removed in the usual way. The omentum is usually ligated when this is included in the wall of the abscess. All compresses are taken out and counted. One or more Iodoform gauze strips (according to the size of the abscess) are layed in the peritoneum and brought directly out through the wound. The wound is closed in layers, as usual, leaving an opening for the packing (to be removed). Three or four silkworm guts are put in (to close the omentum) and are knotted later when the packing is removed. In order to advocate adequate drainage, generally a piece of canvas is placed on top of the gauze to prevent the secretion from the wound from drying out which would destroy the capillary drainage. If the abscess is small, we have recently started removing the packing after 12 to 24 hours and closing the abdominal wound completely. Occasionally we have inserted a thin drainage tube which can be removed two to three days later. With large abscesses or general peritonitis, we carefully pack around all sides, leave the wound completely open, and put in secondary

sutures after the packing is removed two to four days later. As a rule the fascial layers are sutured separately.

Although an appendix operation is very easy when the case is not complicated, it can be very difficult when an abscess has occurred and the adhesions are numerous and tenacious. It is not uncommon that the surgeon must be satisfied with simply opening the abscess and draining it, without being able to remove the appendix; however, this, as mentioned above, is quite regrettable. Although the appendix most probably will shrink in as a rule, and not give cause to more attacks, one has plenty of examples where this is not the case, and thus a danger of relapse exists. Besides, the convalescence is longer and more painful, the abdominal wound must be kept open longer with resultant ventral hernias, the adhesions will cause pain, etc.

As far as I have been able to discover, of these 30 patients, six have already developed ventral hernias. This excludes this year's cases which were operated on too recently to be taken into account, an additional two on which I have no information, and two where the incision was made in the lumbar region. Of the remaining 12 patients who had suffered with suppurative appendicitis, six cases have developed ventral hernias or about 50%. Although this number will undoubtedly be significantly reduced when one, as we have recently, removes the drainage early and sutures carefully afterwards, it is still very impressive. If one compares this with the above group where the operations have been before abscess formation, the difference is striking. As far as I know, no ventral hernias have occurred. A ventral hernia is a very annoying condition, especially for the working man; and since it is equally dangerous and uncertain as an early appendicitis operation, it is strongly and definitely indicated that acute appendicitis should be operated on as early as possible, before the abscess occurs.

General peritonitis was found in six patients of which four died. These patients were all terribly sick at the time of the operative procedure. In one case, No. 39, the patient got better following the surgery. The abdominal wound was closed, but the patient died six weeks later from an abscess in the right lung.

Of the two cured patients, one (No. 10) was operated on the third day after the appendix had ruptured. Profuse washing of the abdominal cavity with salt water and drainage in both iliac areas was performed. The other (No. 67) was operated on only three hours after rupture which occurred when the patient stepped off the train in order to drive to the hospital. In this case the abdominal cavity was not washed out with salt solution but rather the abdomen was carefully dried out with salt water compresses and a large amount of gauze packing was inserted. This was removed the second day followed by secondary suturing of the abdomen leaving a small opening for the tube. I want to comment here that I personally have no faith in the drainage of the peritoneal cavity where infection is universal and that I intend in the future to suture primarily all of these cases after the appendix is removed and the peritoneal cavity is thoroughly washed out (with saline).

There is scarcely a disease group which the last 10 to 15 years of surgical practice has contributed more toward understanding and in which our viewpoint has been more completely changed than inflammations in the ileocecal area. Medical literature and encyclopedias until the present decade have contained no mention of the sickness of appendicitis. One finds articles on typhlitis, perityphlitis, and paratyphlitis while the appendix is mentioned only as a possible cause in rare cases. It is especially to the credit of American surgeons to have shown that the appendix vermiform, rather than the cecum, is almost always the primary cause of inflammations in the right ileac fossa, and that the illness should be the province of the surgeon. We find, for instance, that Willard Parker of New York already in the year 1867 advised early operation of this disease, and in 1883 F F Noyes reported on 100 operative cases of which 90 were done in America. However, it was Reginald Fitz of Boston who first drew the attention of the medical world to this issue in his brochure "On Perforative Inflammation of the Vermiform Appendix," demonstrated the true cause of the disease, pointing out that fecal collection is the usual cause, and not as earlier thought 'foreign bodies;' and finally, that perforation of the appendix does not necessarily cause generalized peritonitis but that this can be localized. He described various forms of this. In 1888 he formulated his diagnosis even more conclusively and established that typhlitis, perityphlitis and paratyphlitis always are one and the same illness as appendicitis. Among the earliest and the most well known American writers about this subject, one can name Doctors Senn, Murphy, and Kristian Fenger and also include our very able countryman Knute Hoegh of Minneapolis. A considerable amount has since been written about this and there exists no particular difference of opinion regarding the illness' etiology and pathology. I will, therefore, only casually and briefly mention the therapy, about which there is still controversy. Essentially the battle is about whether the medical treatment should consist of opium or laxatives and what the indications for and the time of surgery should be.

Regarding the opium treatment, it is usually condemned by surgeons, especially because it masks the symptoms until an operation is usually hopeless. Opiates remove the pain and tenderness which are precisely of such great importance in determining the status and progress of the disease and in controlling

it. Opium causes retention of excrement with resultant distention, making it impossible to decide whether the distention is caused by this or peritonitis. Finally, the opiates cause a false sense of well-being in the patient who, because of this, will be opposed to a necessary operation, which he otherwise might have agreed to.

John Deaver of Philadelphia, who probably is one of the foremost world authorities in this question, says in his work on appendicitis in 1896: "Opium is the medication which most often is responsible for a wrong diagnosis, for the surprise appearance of dangerous symptoms, and for waiting to call in the surgeon until after it is too late. Opium is dangerous in the treatment of this disease or of any intra-abdominal inflammation" (pg 119). He recommends giving a large dose of castor oil, and if this is not tolerated, calomel or saline. In his opinion the danger of a rupture due to administration of an early laxative is not nearly as great as the danger incurred in retention of excrement. In the later stages of the disease, where a barrier is formed to protect the free peritoneum, he recommends not purgatives but immediate operation. A C Bernays in "My Recent Work in Appendicectomy" (1898) strongly discourages the use of opium and declares it to be the worst treatment and most worthy of condemnation. Sonnenburg likewise advocates a mild laxative in the beginning of the sickness.

Recent experiments appear to speak for laxative. For instance, Ewal and Schnitzler have shown that the resorptive power of the peritoneum is very much diminished by opium, and W Noetzel of Konigsberg has stated that experimental animals whose peritoneum can easily destroy 1000 colon bacilli will usually die of peritonitis from the same size bacilli-injection when peristalsis is paralyzed by opium. Noetzel says that the movements of the intestines will contribute to the spread of infectious bacilli over the entire peritoneum which can then more easily come in contact with and destroy the bacteria (Central, 1898).

Several other experiments point in the same direction. Moreover, it has been the practice for many years to give a laxative as soon as possible after laparotomies, rather than opium as was done previously. The foremost and most experienced surgeons have, in fact, a real fear of using opiates following an abdominal operation. The patient is usually considered to be out of danger when flatus and excrement are passed and everything possible is done so that this can occur as soon as possible. Why should the case be different with appendicitis? It is more sensible to assume that one is dealing with an analogous condition and that it is of tremendous advantage to the patient if he can attain a complete emptying of the bowel, set peristalsis in motion, and thereby increase the peritoneum's resorptive power and germicidal ability. Shouldn't one be even more afraid to use opiates here where one might, in addition to paralyzing peristalsis and decreasing the peritoneum's suction power, also mislead the patient and oneself as well?

That an uncritical and dogmatic use of opium in the more severe cases of appendicitis often causes the disease's nature to be masked, and the operation to be delayed until it is too late, is without question. Likewise, I consider it a certainty that our fear of mild laxatives in the early stage of the disease is absolutely unfounded, and that we, on the contrary, will help our patient to a much greater degree with these than with the opium treatment.

When should one operate for appendicitis? The statistics on mortality due to appendicitis are quite variable. In cases treated by medication only, a few reports place the mortality rate at only 5% to 10%. Others such as Morris report 15%, Fitz 26%. That these percentages differ so greatly is nature, since some reports are based on the prognosis made after one attack and some on a prognosis arrived at by follow-ups on the patient over a period of years. It is difficult to get any accurate statistics in this disease as is easily seen in case No. 13 who, after 15 years of feeling well, suddenly developed an acute attack with perforation and peritonitis and died. If one could follow patients for 20 to 25 years, it is likely that the mortality rate associated with conservative treatment would rise above 25%.

The statistics on the mortality of the operation also vary significantly. A few surgeons operate only on the most desperate cases. Thus, while the most aggressive surgeons like Deaver, Murphy and others only have a mortality rate of 2% to 4%—including cases of peritonitis caused by appendicitis—the more conservative surgeons undoubtedly have a much higher mortality rate.

If one excludes the cases of abscess with local or universal peritonitis, it is found that the mortality rate following operations for appendicitis is extremely low, not over 1% to 2%. (Of our 31 patients, none died.) If, therefore, it were possible to operate in every case of this disease, the mortality rate would be brought down to this percentage, as it is very seldom that perforation occurs until a few days into the first attack. It is then beyond dispute that the surest treatment for appendicitis would be immediate operation in every case and that the mortality of this disease, which every year claims so many victims, would be reduced to a minimum, if this practice were followed. Unhappily, this is not the case for many reasons and one comes to the important question: When should a doctor encourage and when should he insist on an operation for appendicitis?

There is still great discussion and difference of opinion on this matter. Generally, one may say that the American surgeons are more aggressive than the Europeans, but also among the former there is con-

siderable dispute while Deaver, Murphy, Bernays, C Beck, and others advocate operation as soon as diagnosis is made, others, including Fenger and Senn, have a more conservative standpoint. In this they are more like the European surgeons. For example, Doctor Lennander who advises operation: 1) with persistent attacks of appendicitis, even when they are mild; 2) when the attacks increase in intensity; 3) when in spite of treatment there is still resistance in the ileocecal region; 4) when peritonitis threatens to or already has occurred. It may be added that he does advise opium treatment. Lennander's analysis can probably be said to represent the average standpoint among surgeons.

On the more radical side is Sonnenburg who in his excellent article "Pathologie and Therapie der Perityflitis," 1895 and in his speech "Uber Operat. am Proc. Vermiformis" in 1896, gives a thorough picture of appendicitis, both the clinical and the pathological-anatomical aspects. He strongly recommends operation for this disease, although less severe catarrhal forms should be operated only at the patient's insistence.

But who can decide clinically that a special case belongs to the lesser diagnosis of catarrh cases? Is one ever at all able to make a favorable prognosis by medicinal treatment? Absolutely never with certainty. Everybody agrees that from the clinical symptoms one can in no way determine the degree of the disease's severity, for example, the ulceration depth or the potential for perforation. Without any warning or immediate cause, perforation can thus occur and cause deadly peritonitis (cf Nos. 12, 15, 44). If one has had an attack of appendicitis, one is in constant danger of having a recurrent attack with possible perforation. The patient becomes anxious, the pain from adhesions is a reminder of his weakness, digestive problems are often present, and work strength disappears. The insurance companies deny life insurance. Only an operation can bring complete cure. If it is done prior to abscess formation, the surgery is practically without risk and leaves neither ventral hernia nor adhesions. (Deaver operated approximately 200 cases in 1897 with one death, A C Bernays 81 cases with one death.)

(1) In a mild, "catarrhal" case of appendicitis, one may choose on the one hand, nonsurgical treatment which, of course, in all likelihood will provide a temporary cure, but will also entail a high probability of recurrence even after 10, 15, or 25 years. In addition, one has to contend with the above-mentioned discomforts and dangers, which are present in varying degree and may cause the patient several years of being an invalid. On the other hand, one has surgical treatment with a much lower fatality rate, a guarantee of lasting and complete cure with full ability to work, access to life insurance, etc. I want to reemphasize here that a 'cure' by medicinal treatment in this illness is absolutely no cure in the greater percentage of cases, but only an improvement between attacks. One cannot point to a single case where one can assure the patient that he is definitely cured, even though the attack was very mild.

In the mild forms it is our duty to present the alternatives to the patient so he can decide for himself about having surgery done. One must be especially certain not to hide from him the dangers which he may encounter in the future. If one fails to make the risks known, one is as a physician taking upon himself a great responsibility for any fatal recurrence in the future.

In connection with this, I want to present a case which occurred a short time ago in Doctor Christensen's and my practice. A young strong laborer who could not remember having a sick day in his life had a slight pain in his abdomen one evening, especially localized over the appendix area where there was sensitivity to pressure. He nonetheless was ambulatory all the while and did not consider himself very sick. His temperature did not exceed 38 C. Only 48 hours after the first appearance of pains in the lower ileocecal region, perforation occurred with terrific universal generalized peritonitis. When I saw the patient for the first time 12 hours later, he was pulseless, suffering cold sweats, cyanotic, and had an extremely hard, but very tender lower abdomen and subnormal temperature. Autopsy showed generalized suppurative peritonitis caused by a totally gangrenous perforated appendix. Laparotomy was not attempted.

This case, which, of course, before perforation had to be categorized with the unusually light "catarrhal" cases, is prime evidence of how impossible it is here to arrive at a clear prognosis. Not a single symptom gave any warning of the imminent danger the man was facing. Also No. 49 who, without having been unable to work for a single day, suddenly showed universal fatal peritonitis. The entire appendix was black and gangrenous without having shown any symptoms. That these patients and many similar cases could have been saved with immediate operation is certainly without question.

(2) In cases of recurrent appendicitis even though the attacks have been minimal, or (3) where thereafter one attack remains tenderness over the appendix, and even more so (4) where one can palpate resistance or a tumor, surgery is absolutely indicated. (5) During an attack one should operate immediately when the symptoms are not improved by the third or fourth day, if laxatives are being used.

That an operation is easier and more pleasantly carried out between attacks than during an attack is certainly true, but this advantage does not by any means outweigh the danger one places the patient in by letting him recover from the attack even though it seems to be very light. There is almost no increased danger of infection in the peritoneal cavity when one

operates during an attack, contrary to what some people assume, given, of course, that perforation has not occurred.

In conclusion, I would like to quote the well-known Doctor Osler, Professor of Internal Medicine at Johns Hopkins University in Baltimore, who states, regarding appendicitis in 1895, "There is no medicinal treatment. Surgery is indicated whether tumor is present or not when the symptoms on the third day point toward progressive disease."

P.S.

Since the first of July, 1898, when the previous article was written, we have operated 22 appendicitis cases which along with the previous 67 cases, totals 89 cases since the first of July, 1894.

Of these last 22 cases, nine were operated on before perforation or abscess formation. All recovered. One case of suppuration occurred in the abdominal wall because of hemorrhage in the subcutaneous area which necessitated opening of the wound and secondary suturing. In seven cases there was localized intraperitoneal abscess. These were also cured.

One case developed a subdiaphragmatic abscess which spread into the pleura. This was in a 40-year-old male who had been sick and essentially bedridden for three months. The attending physicians had diagnosed typhus. The appendix was tremendously enlarged, about the thickness of the index finger, extending upward toward the diaphragm and adherent to the kidney capsule. It was perforated at this point, embedded in pus and very difficult to remove. It contained in the distal end a fecolith and near the base a date pit. The operative wound healed very rapidly following removal of the packing the third day. However, in spite of the patient's well being, he was febrile up to 38.5 and 39.0 C in the evenings. Gradually he developed a consolidation of the right lung with pronounced tenderness over the ninth and tenth ribs posteriorly. Occasional coughing produced bloody purulent expectorations. In spite of repeated punctures with long, thick needles, no pus was encountered. With his condition gradually worsening, resection of the ninth rib was done posteriorly. After opening of the pleura, a large abscess cavity was encountered with stinking pus which extended upward to about the fourth costal rib. Below this cavity an opening was felt, leading into the diaphragm, large enough to admit the index finger. There was also perforation of the lung. Afterwards, the patient recovered rapidly.

Six patients had generalized peritonitis on admission. Laparotomy was done in all. Four died and two were cured. One of these who recovered had had a violent attack of peritonitis two weeks prior to surgery. The appendix was adherent and perforation low in the pelvis. Over the entire abdomen there were adhesions between the intestinal loops without any exudate. Removal of appendix was done and drainage for four days. The patient recovered rapidly. The other of the two, a boy aged 12, had been sick for five days with his first attack. The abdomen was not distended or hard. He vomited a few times, had no signs of obstruction, and very little increase in temperature, but a very definite peritonitic facies. At laparotomy, the entire peritoneal cavity was found to be filled with thin, purulent, stinking fluid. The appendix was removed with complete flushing of the cavity especially up towards the cardia and in the pelvis with salt water. The small bowel was freed of coating and an incision was also done in the left iliac region. As the patient seemed completely hopeless, the small bowel was punctured in two places with the use of hollow needle and injected with 30 grams of magnesium sulfate dissolved in about ½ liter of water. Following this, a gauze drain was inserted in both incisions as usual. The patient was very fatigued following the operation. For this reason salt water infusions were given. The following day the patient had three loose bowel movements and improved, contrary to expectation. He is now out of danger. I have never seen this treatment referred to anywhere previously, but I am of the belief that this patient's life was saved by the introduction of this relatively large dose of laxative into the bowel, thus inducing the desired peristalsis.

January 12, 1899.

(Attached to the original article was an appendix tabulating name, age, dates, history, operation, and the results of the 67 cases.)■

HAVING LEFT NORWAY in 1891 to seek adventure, earn enough money to repay his school debts, and then expecting to return to his native Norway within a couple of years, Adolf Gundersen settled in La Crosse where he founded one of the most respected medical establishments in the nation. La Crosse Lutheran Hospital was established in 1899. In 1930 a new clinic opened on the site of the present clinic facility—the Gundersen Clinic, Ltd, which celebrated its Fiftieth Anniversary last year.

"From the very beginning of his practice in La Crosse, Adolf Gundersen's desire to learn, his constant study and attention to detail created a heritage for excellence in medicine that still exists today at the institution which bears his name. The tradition of this medical experience has been carried on not only by the sons, grandsons, and colleagues of Adolf Gundersen, but also by all active staff physicians." —Commemorative Booklet: *Gundersen Clinic, Ltd, La Crosse, Wisconsin 1930-1980*

Coexistence of blastomycosis with epidermoid carcinoma of the lung; case report

Mehboob M Qureshi, MD, Monroe, and **Helen M Dickie, MD,** Madison, Wisconsin

ABSTRACT. *The authors describe an unusual case of a Green County resident who simultaneously had North American blastomycosis* (Blastomyces dermatitidis) *and epidermoid carcinoma of the lung. This case report is presented to alert physicians to the need for an accurate tissue diagnosis before definitive therapy for carcinoma of the lung is undertaken without excluding the diagnosis of non-neoplastic disease which may mimic bronchogenic carcinoma. This patient's first lesion was blastomycosis. The development of the lesion in the opposite lung, after successful therapy of blastomycosis, makes the need to recognize the new lesion as likely to be a bronchogenic carcinoma.*

BLASTOMYCOSIS is an uncommon but an ubiquitous disease.[1] The coexistence of blastomycosis with histoplasmosis and tuberculosis is well known.[1,2,3,4] The coexistence of blastomycosis with carcinoma of the lung is rare.[4,5] To date, four cases of blastomycosis associated with "scar" adenocarcinoma have been described. We believe this is a first reported case of blastomycosis coexisting with an epidermoid carcinoma of the lung.

CASE REPORT. A 58-year-old man, who is a lifelong resident of Green County, Wisconsin, was admitted to St Clare Hospital, Monroe, Wisconsin, on October 7, 1977, because of alcohol abuse. A routine chest x-ray film showed a large mass in the anterior segment of the right upper lobe (Fig 1). He worked in a plant producing cans of condensed milk. He had no symptoms referable to his chest. He gave a 40-pack a year history of cigarette smoking. In 1964 a squamous cell carcinoma of the floor of the mouth had been removed by wide surgical excision. There was no evidence of local metastatic node recurrence of this tumor.

The patient's sputum was examined for acid fast bacilli and fungi and none was found. The cytological studies of the sputum showed no tumor cells. Bronchoscopy revealed no evidence of any bronchial abnormality. A transbronchial biopsy was not done.

Considering the high-risk factors of cigarette smoking and the previous oral squamous cell cancer, the pulmonary lesion was felt to be a bronchogenic carcinoma, and surgical intervention was advised. A biopsy of the mass revealed a granuloma, and an organism compatible with *Blastomyces dermatitidis* was seen. This was subsequently verified by culture.

With a diagnosis of blastomycosis, no surgical removal was done. The patient was subsequently treated with amphotericin B to a total dose of 2.0 gm which he tolerated well. The patient's lesion in the right lung cleared, and there was very little residual scarring evident.

In a subsequent observation of the patient in 1979, the chest x-ray films revealed a slowly enlarging parenchymal lesion in the left upper lobe which was present in his previous x-ray films of October 1977. The original site of the blastomycosis in the right lung showed no evidence of recurrence (Fig 2).

Again, attempts to isolate fungi, acid fast bacilli, and tumor cells failed. We concluded that the lesion in the left lung was a carcinoma that had coexisted with blastomycosis. A left thoracotomy revealed a squamous cell carcinoma, Grade III, and the left upper lobe was removed. There was no evidence of lymph node involvement. The patient has remained well without any recognized evidence of metastatic spread of the carcinoma or recurrence of blastomycosis.

DISCUSSION. This patient represents one of the problems encountered in the diagnosis and management of patients with a nodule or a mass lesion found in a routine chest x-ray film. Today, before performing a thoracotomy, we would recommend fiberoptic bronchoscopy with biopsy of the lesion. This procedure has a high yield of providing the diagnosis in carcinoma, fungal diseases and, in rare cases, where fungus and/or tuberculosis coexist with carcinoma. Another important consideration is to make certain that the lesion is not a small-cell carcinoma. The results of surgical treatment of

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FIGURE 1—*Admission chest roentgenogram showing mass lesion in upper lobe of right lung.*

FIGURE 2—*Follow-up chest roentgenogram showing clearing of lesion in the right lung and a mass in the upper lobe of the left lung.*

small-cell carcinoma have been so disappointing that we would not recommend a thoracotomy.

The same approach should be used for the second lesion for the same reasons. The question of relapse due to drug resistance is usually raised in such instances. Fungal species do vary in their susceptibility to amphotericin B and resistance has been reported in at least one species (*Candida tropicali*), but clinical resistance by *Blastomyces dermatitidis* has not been reported. The likelihood of relapse after 2.0 gm of amphotericin B is rare, although such cases do exist in the literature.[6,7,8,9] In one instance two cases did not show a clinical response after a cumulative dose of 5.0 gm of amphotericin B, although *in vitro* studies showed the organism to be susceptible to amphotericin B.[10] In such cases a host factor; *eg,* immunodeficiency, is the most likely reason for the lack of clinical response.[11] In our case we did not feel that a host factor or resistance to the drug was the issue. The slow rate of growth and absence of regional nodes would make a small-cell carcinoma highly unlikely. With the risk factors, a history of oral squamous cell carcinoma and the radiographic pattern, the patient's lesion was felt to be a bronchogenic carcinoma.

This patient demonstrates very well that the diagnosis of blastomycosis requires the demonstration of the organism, either from secretions or tissue specimens. The development of another area of involvement in the lung is rare in a patient who has been treated adequately with amphotericin B and requires the same careful evalution to establish the etiology of the new lesion, rather than accepting it as a recurrence of blastomycosis.[6]

SUMMARY. Blastomycosis can coexist with tuberculosis, histoplasmosis, and carcinoma. At times sputum studies or bronchoscopy may provide the answer but quite often the question cannot be settled without resorting to an exploratory thoracotomy.[4] This case report emphasizes the importance of having a tissue diagnosis before starting medical therapy or performing a surgical procedure, such as lobectomy or a pneumonectomy for a presumed carcinoma.

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Patient evaluation of clemastine fumarate and comparison with other antihistamines

Robert J Kriz, MD, Madison, Wisconsin

ABSTRACT. *A total of 203 patients suffering from perennial allergic rhinitis, vasomotor rhinitis, seasonal allergic rhinitis, and urticaria assessed the benefit and degree of drowsiness caused by various antihistamines and antihistamine-decongestant combinations. Clemastine fumarate (Tavist® Dorsey), 2.68 mg tid, was administered to 108 patients, and 45% of the perennial allergic rhinitis patients and 55.1% of the seasonal rhinitis patients reported good-to-excellent responses. Males were as likely to benefit from clemastine fumarate (CF) as females. In trials with other antihistamines and antihistamine-decongestant combinations, CF produced at least as effective results and, in most instances, it was more effective in providing relief. Based on our clinical trials, CF does not appear to induce significant drowsiness in a majority of patients. Effectiveness ratings were similar for all age groups except in the over 40 group, which experienced greater benefit from the drug. However, this age group also reported the highest incidence of drowsiness. Few side effects were noted, the most serious being gastrointestinal intolerance, which occurred in one patient. CF appears to be an antihistamine with a low drowsiness profile effective in the treatment of various allergic conditions.*

CLEMASTINE FUMARATE (CF) (Tavist® Dorsey) possesses a chemical structure similar to that of other antihistamines in the benzhydryl group, most notably diphenhydramine and chlorpheniramine. It has been shown in various studies to be useful in the treatment of allergic rhinitis, seasonal and dermatologic allergies, and vasomotor rhinitis.[1,2,3] One of the significant advantages attendant to its use is that the drowsiness induced by the drug is less than usually occurs with antihistamines. In this retrospective study we sought to determine both the efficacy and drowsiness-inducing capacity of CF when compared with other antihistamines or antihistamine-decongestant combinations.

MATERIALS AND METHODS. Two hundred and three patients were given a two- to three-day trial of three to six antihistamines or antihistamine-decongestant combinations and asked to assess benefit on a 0 to 3 scale (0 = poor, 1 = fair, 2 = good, 3 = excellent) and drowsiness (0 = not drowsy, 1 = mildly drowsy, 2 = drowsy, 3 = disabling drowsiness). Patients took each drug every six to eight hours and indicated which drug in the trial pack they preferred, which subsequently was prescribed.

Criteria for entry into the study included symptoms of rhinitis with previous inadequate control, failure of prior antihistamine treatment, or side effects with prior drug administration. If a patient suffered from high blood pressure, no antihistamine-decongestant combinations were given. In addition, all other types of therapy, such as steroid nasal sprays, were continued during the trials. Patients were advised not to drink alcoholic beverages, drive, or engage in dangerous work while taking the medication.

RESULTS. Of the 203 patients included in the study, 108 were exposed to CF. Forty-nine had seasonal allergic rhinitis, 40 had perennial allergic rhinitis, 14 had vasomotor rhinitis, 4 had urticaria, and 1 had an unidentified condition.

Table I illustrates the responses based upon clinical diagnoses. Patients with vasomotor rhinitis had negative skin tests, while patients with perennial allergic rhinitis and seasonal allergic rhinitis had positive skin tests. Patients with vasomotor rhinitis generally exhibited the poorest response to the drug, with 4 of 14 patients (28.6%) reporting poor results, while only 6 of 40 (15.0%) patients with perennial rhinitis and 9 of 49 patients (18.4%) with seasonal allergic rhinitis indicated the same poor response. Patients with perennial allergic rhinitis and seasonal allergic rhinitis reported the most favorable response to the drug, with good-to-excellent responses of 45% and 55.1%, respectively. It also should be noted that all four patients suffering from urticaria experienced some degree of improvement. Effectiveness ratings for CF were similar in both sexes.

One-half (54) of the patients reported no drowsiness with CF, 36 (33.3%) were mildly drowsy, 15 (13.9%) were drowsy, and only 3 (2.8%) had disabling drowsiness. Similar percentages occurred when the drowsiness was broken down by sex.

Although CF appeared to be more effective in patients over 40 years of age, this group also was more likely to encounter drowsiness as a side effect.

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TABLE 1—*Effectiveness of clemastine fumarate (CF)*

CONDITION	EFFECTIVENESS				
	POOR	FAIR	GOOD	EXCELLENT	TOTAL NO. PATIENTS
Vasomotor rhinitis	4 (28.6%)	3 (21.4%)	6 (42.9%)	1 (7.1%)	14
Perennial allergic rhinitis	6 (15.0%)	16 (40.0%)	15 (37.5%)	3 (7.5%)	40
Seasonal allergic rhinitis	9 (18.4%)	13 (26.5%)	17 (34.7%)	10 (20.4%)	49
Urticaria	0	1 (25.0%)	2 (50.0%)	1 (25.0%)	4

TABLE 2—*Effectiveness of clemastine fumarate (CF) vs other antihistamines and antihistamine-decongestant combinations*

DRUG	EFFECTIVENESS				
	POOR	FAIR	GOOD	EXCELLENT	SAMPLE SIZE*
CF	19 (17.6%)	34 (31.5%)	40 (37.0%)	15 (13.9%)	108
Hx, DH, or CM	40 (25.2%)	50 (31.4%)	60 (37.7%)	9 (5.7%)	159
All 9 AHs	129 (23.2%)	186 (33.4%)	194 (34.8%)	48 (8.6%)	557
All 7 AH-DCs	198 (20.8%)	318 (33.4%)	325 (34.1%)	111 (11.7%)	952

*Sample size indicates number of patients trying at least one of the antihistamine or antihistamine-decongestant combinations.

Hx = hydroxyzine hydrochloride
DH = diphenhydramine hydrochloride
CM = chlorpheniramine maleate

AH = antihistamine
AH-DC = antihistamine-decongestant combination

TABLE 3—*Incidence of drowsiness with clemastine fumarate (CF) vs other antihistamines and antihistamine-decongestant combinations*

DRUG	DEGREE OF DROWSINESS				
	NOT DROWSY	MILDLY DROWSY	DROWSY	DISABLING DROWSINESS	SAMPLE SIZE*
CF	54 (50.0%)	36 (33.3%)	15 (13.9%)	3 (2.8%)	108
Hx, DH, or CM	77 (48.4%)	43 (27.0%)	31 (19.5%)	7 (4.4%)	159
All 9 AHs	309 (55.5%)	137 (24.6%)	93 (16.7%)	15 (2.7%)	557
All 7 AH-DCs	521 (54.7%)	255 (26.8%)	147 (15.4%)	26 (2.7%)	952

*Sample size indicates number of patients trying at least one of the antihistamine or antihistamine-decongestant combinations.

Hx = hydroxyzine hydrochloride
DH = diphenhydramine hydrochloride
CM = chlorpheniramine maleate

AH = antihistamine
AH-DC = antihistamine-decongestant combination

CF rated more excellent responses than the total group of other antihistamines and antihistamine-decongestant combinations, and only 17.6% of CF patients gave it a poor rating as opposed to 23.2% for all of the antihistamines and 20.8% for the antihistamine-decongestant combinations (Table 2). In addition, CF was more effective than hydroxyzine hydrochloride, diphenhydramine hydrochloride, or chlorpheniramine maleate (17.6% failure rate as opposed to 25.2%). The incidence of significant drowsiness also was generally less with CF (Table 3).

Trials comparing CF with tripelennamine indicated that CF was as likely to be rated good or excellent (65% for CF vs 61% for tripelennamine), but CF was less likely than tripelennamine to have a "not drowsy" rating (44% vs 76%). No differences were noted between CF and brompheniramine maleate.

DISCUSSION. CF has been shown in this study to be one of the more effective antihistamines for relief of seasonal allergic rhinitis and perennial allergic rhinitis. In addition, the drug is well tolerated and, in many patients, induces less drowsiness than many of the other currently prescribed antihistamines and antihistamine-decongestant combinations. It should be noted that CF was more effective than the majority of available antihistamine-decongestant combinations in the trial pack.

Although the most common side effect noted was drowsiness, several patients also complained of dryness of the mouth, nose, and throat, and one patient noted gastrointestinal intolerance. No rash, headache, dizziness, photosensitivity, hypotension, tachycardia, or irritability was reported. No patient with asthma reported either thickening of bronchial secretions or increased wheezing. There were no adverse interactions between CF and other medications the patients may have been taking.

Based upon our experience, a trial with CF is indicated for patients suffering from allergic conditions. If CF becomes available as a preparation incorporating a decongestant at some point in the future, clinical trials would be most interesting.

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ABSTRACT

Early gastric cancer: Report of five cases

Dr Eugene E Eckstam of Monroe has published an article in *Gastrointestinal Endoscopy* (27[3]: 174-175, August 1981) in which he reported performing 2500 gastroscopies or "gastrocameras" in a ten-year period from 1969-1979. Five patients with very superficial stomach cancer confined to the surface layers only were identified on the gastroscopic examinations. This ratio of 1 in 500 compares with a national ratio of 1 per 1000 gastrocamera examinations. All five patients are still alive and well. Two of them are well over five years, and a third one is approaching the fifth year of survival. Most patients with cancer of the stomach do not survive four or five years. ■

Anaerobic bacterial meningitis

RICHARD M REICH, MD and DENNIS G MAKI, MD (University of Wisconsin Hospital and Clinics, Center for Health Sciences, Madison, Wis): *Current Chemotherapy and Infectious Disease,* Proceedings of the 11th ICC and the 19th ICAAC, American Society of Microbiology, 1980

Experience with three cases of meningitis caused by anaerobic bacteria prompted the authors to initially review the literature on reported cases to determine when cerebrospinal fluid (CSF) should be cultured anaerobically. Using information obtained from this review, they have subsequently identified 2 more cases, giving 5 among 272 cases of bacterial meningitis treated in their hospital over a five-year period. Only two cases of meningitis were reported to have been caused by anaerobes in four large published series of bacterial meningitis encompassing 1,027 cases, an incidence of only 0.2%. The authors experience (anaerobes implicated in 1.8% of cases of bacterial meningitis) suggests that many cases are not being identified because CSF is not cultured anaerobically. They describe the typical setting and clinical features of anaerobic meningitis and salient aspects of its laboratory diagnosis and management, based on 88 reported cases, including their own.

Based on their experience with five cases of anaerobic meningitis and an analysis of 83 reported cases, they recommended that CSF be cultured anaerobically in suppurative meningitis associated with: (i) parameningeal infection, (ii) cranioaxial trauma, recent craniotomy, or surgery on parameningeal structures, (iii) anaerobic bacteremia, (iv) negative aerobic cultures, or (v) smears or cultures suggesting polymicrobial meningitis. ■

Regulation bills command Board's attention

The SMS Board of Directors in November informed the State Medical Examining Board of the Society's position on legislative proposals which would amend the Pharmacy Practice Act and revamp the Department of Regulation and Licensing.

In a letter to Medical Board members, SMS Board Chairman Darold A Treffert, MD, Fond du Lac, said the State Medical Society is strongly opposed to the pharmacy practice bill (SB 437) as currently proposed.

Doctor Treffert said that while the Society supports appropriate labeling and recordkeeping by physicians who dispense, it does not think that the Medical Examining Board "should remove itself from both its responsibility and authority for the control of physician dispensing practices."

The SMS Board reaffirmed its previously established opposition to any revamping of the Department of Regulation and Licensing whereby the Medical Examining Board abrogates its responsibility for rulemaking.

At its November 7 meeting, the SMS Board of Directors voted to invite members of the Medical Examining Board and Dept of Regulation and Licensing Secretary Ann Haney to the Board's January 16 meeting to further discuss the general issue of regulation and licensing in Wisconsin.

In other action November 7, the Board:

- Approved a sample "Preservice Agreement Form" which will be made available to any SMS member upon request.
- Adopted a statement on "Reimbursement Guidelines for Mental Health Coverage under WPS Contracts" drafted by the SMS Mental Health Committee.
- Appointed Dennis J Kontra, MD, Racine, to the SMS Physicians Alliance Commission.
- Requested Board members to contact their legislators and petition the restoration of the Governor's language in the Budget Repair Bill which would include medical psychotherapy as a covered service under Medicaid if it is "provided directly by a psychiatrist." ■

THE BEAUMONT 500

The Aesculapian Society of the SMS Charitable, Educational and Scientific Foundation has established a Medical Museum Endowment Fund to fund the operation and maintenance of the Fort Crawford Medical Museum at Prairie du Chien. The goal is to establish a permanent fund of at least $500,000, the corpus of which will not be utilized for any purpose except the production of income which, in turn, will be earmarked for museum operations.

Physicians who make a "once in a lifetime" contribution of $1,000 or more to the endowment fund will become members of a select group of physicians known as the "Beaumont 500." In addition to belonging to this prestigious group, physicians who contribute $10,000 or more will receive a first edition copy of Dr William Beaumont's famous book: *Experiments and Observations on the Gastric Juice and Physiology of Digestion,* first published in 1833.

For more than 20 years, the Fort Crawford Medical Museum has helped familiarize citizens with the fascinating people and events that have helped shape Wisconsin medicine. Your gift to the Medical Museum Endowment Fund will help preserve Wisconsin medical history for future generations. Please consider making your gift today. ■

Women physicians hold district meeting

Women physicians representing seven counties in the ten-county area from the Fox River Valley to Green Bay met in Green Bay the evening of November 11 for a District Meeting of Women Physicians. The SMS Committee on Women Physicians is organizing district meetings around the state to give women physicians an opportunity to meet other women physicians in the area and to share mutual concerns.

The program included Cathryn Olsen, tax investment counselor from Conglianese-Stadtmueller who spoke on "Personal Financial Planning and the Implications of the Economic Tax Recovery Act of 1981," and Nancy Rottier, an attorney who spoke on property reform in Wisconsin.

The event also attracted the attention of the local media. WBAY-TV news in Green Bay aired a story on the district meeting and on how women physicians are becoming more commonplace throughout the state.

The SMS Committee on Women Physicians was created by the SMS Board of Directors in May 1980 to serve as liaison and women's advocate with other committees and commissions of the State Medical Society, and to serve as a resource on women's health issues.

Currently, the Committee is dealing with the issues of the politics of organized medicine, sexual harassment, and premenstrual syndrome. ■

Society leaders focus on the future

The State Medical Society of Wisconsin took a look at its future and the future of medical practice at the Brookfield Marriott last month during a two-day leadership conference for state, county, and specialty society representatives and medical auxilians.

The purpose of the meeting was to have medical leaders address issues that the SMS Board of Directors perceived to be the primary concerns for the next two to three years. The idea wasn't to present simply another "horse and pony" show on various topics, but rather, to bring together physician leaders from throughout the state to exchange their ideas, concerns and thoughts on how organized medicine might deal with these issues and what priorities it might attach to them.

Following are some of the highlights of each of the panels presented during the meeting:

• **SMS Services, Inc. and what it can do for doctors:** SMS Services, Inc was formed to expand the number and quality of "tangible" benefits available to SMS members, while at the same time return all profits back to the SMS as stock dividends. SMS members are encouraged to take better advantage of the "good buys" available to them on the following programs: an endorsed debt collection service, a furniture discount program, auto rental and leasing programs, book discount programs, seminars on financial planning, uniform claim form, special tours for members, as well as updated insurance programs and serving as a licenced insurance agency for members.

• **Why doctors should work with business and labor:** Business has taken a new interest in controlling health-care costs in light of escalating disability and health insurance premiums for employees. Coalitions between business and labor and physicians should be formed at the county medical society level to explore ways to relieve the problem.

• **Future of health planning:** With health planning slated for phaseout by the Reagan administration, there is now a bill pending in Congress which would repeal the Federal Health Planning Act. The SMS Health Planning Commission supports this bill but is petitioning the Wisconsin Congressional Delegation to make federal funds available in block grants to states for *locally-based, voluntary* health planning.

• **The role of organized medicine in public and private proposals to change reimbursement of physicians:** State government is committed to changing the reimbursement to physicians under the Medicaid program, and it is almost certain that this change will involve some type of uniform fee methodology. A tax credit concept was proposed as an alternative for financing Medicaid. SMS President Motzel urged a return to an idemnity fee schedule approach to insuring physician services.

• **Is another malpractice crisis coming?:** Not to Wisconsin in the foreseeable future. WHCLIP, the panel system, and other legislative changes have been successful in stabilizing the malpractice system in Wisconsin. However, WHCLIP's tax status is being challenged, physicians are unduly reticent to serve on Patients Compensation Panels and there is need for better malpractice prevention programs. Should physicians be considering an alternative to WHCLIP, given the philosophy of Governor Dreyfus and the insurance commissioner who feel that government should not be doing anything private industry can do? SMS experts say "no" for now.

• **Political effectiveness—can we keep it?:** This is not time for complacency among physicians when one considers the issues of uniform fees, the Medicaid budget, the changing trends in regulation and licensing, the cost of medical care, and the growth and medical practice dreams of allied health professions. The SMS Physicians Alliance should, in addition to concentrating on its political action and legislative activities, devote more attention to research-analysis, assistance on local issues to county medical societies, issue papers, and find solutions to the rising cost of medical care.

continued next page

CES FOUNDATION

CONTRIBUTIONS—OCTOBER 1981

The Charitable, Educational and Scientific Foundation of the State Medical Society is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for October 1981.

Unrestricted

La Crosse County Medical Society Auxiliary; Thomas A Leonard, MD—*Voluntary Contributions*

Restricted

State Medical Society—*Grant for Wisconsin Work Week of Health*

EJ Nordby, MD—*Beaumont 500 Club*

Memorials

Rhea Schulz—*Phillip Kephart; Alyce Gillette (Student Loans)*

Dr-Mrs Stephen D Austin—*Merle Hadley (Brown County Loan Fund)*

Joan Janssen—*Dorothy Parks Reinhardt (Aesculapian Society)*

Dane County Medical Society—*Todor Gencheff, MD*

B Jaye Anno; H Kent Tenney, Jr, MD; State Medical Society—*Dorothy Parks Reinhardt*

LeRoy A Johnson—*Bill Angell*

State Medical Society—*Clarence H Boren, MD; Elmer E Debus, MD; Robert L Demke, MD; John W Prentice, MD; Joseph W Steckbauer, MD; Todor Gencheff, MD; Richard D Jeffries, MD* ■

• **Organizing for effective action—a survey of county societies:** A survey of 30 county medical society secretaries showed that the major concerns at the local level were cost of medical care, competition from non-MD providers, surplus and distribution of physicians, Medicaid and Medicare. County societies want more "packaged" meeting programs from SMS both scientific and socio-economic, and better liaison with hospital medical staff affairs: *Medigram* and *Wisconsin Medical Journal* are their major sources of information; SMS field staff was next.

• **SMS priorities for 1982-83:** The State Medical Society's biggest problem seems to be membership complacency (not apathy)—this needs immediate study. SMS should expand its communications with county medical societies on current events. While politics is important, SMS must not lose sight of other important endeavors such as public education and public health. SMS priorities seem to be in the right order, but the Society should continually evaluate the effectiveness of its programs. ■

Annual Meeting resolution deadline

The 1982 House of Delegates sessions will be held May 13-14. All resolutions must be submitted in proper form to the Secretary's office at SMS no later than March 13, 1982 (two months prior to the first session of the House). It is important that county medical societies, specialty sections, and members submit resolutions early to facilitate early distribution of materials and allow all delegates to adequately represent their county medical society or specialty section. If a resolution involves expenditures, a "fiscal note" must accompany the resolution. SMS staff is available to assist in preparation of fiscal notes. The first session of the House will convene on May 13 and the second and third sessions will be on May 14, 1982. ■

TIME FOR CESF

Christmas is a time for giving. This Christmas, remember the Charitable, Educational and Scientific Foundation of the State Medical Society when making your charitable contributions. CESF was created by the State Medical Society in 1955 to permit physicians and others to present gifts or other forms of support to projects vitally affecting medicine and health of the people of the state. Gifts to the Foundation may take a number of forms: cash, life insurance securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Gifts may be unrestricted, permitting the trustees to use the funds for any purpose for which the Foundation was created. They may also be restricted or earmarked for specific purposes of interest to the donor. All contributions to the Foundation are deductible for income tax purposes. ■

Rentmeester, Kindig cite problems in healthcare

According to the new administrator for the State Division of Health, state government "can no longer afford to be on an adversarial track with physicians." Kenneth Rentmeester told physicians during a luncheon address at the SMS Leadership Conference November 7 that he viewed physicians as having the most important role in healthcare costs.

"While physicians realize only 10% to 15% of healthcare costs, they control 80% of what is being done in healthcare," Rentmeester maintained.

Stating it was urgent that changes be made now in the Medical Assistance program, Rentmeester advocated redesigning the system to provide both consumer and provider incentives to keep costs down.

Speaking to physicians at that same conference was David A Kindig, MD, vice chancellor for health sciences at the University of Wisconsin, who concurred with Rentmeester's view that costs is the number one problem in healthcare.

Doctor Kindig proposed that perhaps the true costs of healthcare were not due to increased technology or services, such as CAT scans, but rather are due to "individual professional decision-making."

He urged physicians to "put more thought into our everyday decisions concerning healthcare delivery and utilization." ■

Physicians honored for contributions to maternal health

Seven former members of the SMS Maternal Mortality Study Committee have been awarded a "Citation of Special Merit" from the committee in appreciation for years of effort to make motherhood a safer process. Those persons who received the honor are: Amy Louise Hunter, MD, Green Valley, AZ; Alice D Watts, MD, Oregon; Helen Callan, RN, Franklin, IN; William Kreul, MD, Racine; Edward A Birge, MD, Milwaukee, and Ben M Peckham, MD, Madison. ■

"WATS" LINE FOR MEMBERS

As a service for its members, the State Medical Society of Wisconsin has a **toll-free** WATS line (Wide Area Telecommunications Service) to provide member physicians with quick and easy access to SMS staff. The in-WATS line can be used to contact anyone at SMS headquarters (330 East Lakeside Street, Madison) from anywhere within the State of Wisconsin between the hours of 8:00 am and 4:30 pm weekdays. The number to dial is:

1-800-362-9080

SENIOR PHYSICIANS

Don't sit home, shake up your jelly beans

Retirement. It's something many physicians face with uncertainty and uneasiness. After devoting a lifetime to the practice of medicine, how does one rearrange one's lifestyle and activities to take its place? "Letting senior physicians know that they still can make substantial contributions to medicine and their communities in their retirement years is a major purpose of the Wisconsin Association of Senior Physicians," according to its new president, Norman Clausen, MD, Mazomanie.

The association recently held its first annual meeting October 17 at SMS Headquarters where more than 120 physicians and their spouses turned out for a day designed to provide both intellectual stimulation and social enjoyment. As an added feature this year, exhibits of painting, sculpture, woodworking, photography and other hobbies, interests or talents of the senior physician members were on display during the meeting.

During the morning program session, the senior physician group was updated on the Economic Tax Recovery Act of 1981 and was given advice on financial and investment aspects of estate planning from two members of the Trust Department of First Wisconsin Bank of Madison: Jack Maynard and Tom Plumb.

That afternoon, Margaret Prouty, MD, told attendees how they might approach their retirement years. Doctor Prouty encouraged her senior physician friends to actively pursue their interests and hobbies, or, as she so distinctly put it: "Don't sit home, shake up your jelly beans."

Speaking on the topic: "Physicians, Fleas and Faith," SMS Secretary and General Manager Earl R Thayer reminded the audience of the great medical heritage which they share. He spoke of "those men and women of medicine who perhaps were little known to the general public, but who did much to make medicine great in this state."

Robert Murphy, Esq gave an account of what life and practice is like for professionals behind the iron curtain, based on his recent travels to the East European countries. Physicians in these countries are very restricted in their practices, he said, working out of store fronts or out of their homes, but seldom out of the clinics—except of the largest cities. "You have no mobility. You are told where you will go and what you will do, unless you are an acknowledged specialist," he said.

Howard Correll, MD

Thomas Leonard, MD

Norman Clausen, MD

Eugene Eckstam, MD

Harold Kief, MD

Margaret Prouty, MD

Tom Plumb

Jack Maynard

Robert Murphy

Returning to share more of his wit and wisdom through his "select readings" this year was Harold McCarty, professor emeritus of Radio & TV Education at the University of Wisconsin-Madison.

The final portion of the day was devoted to business where the group elected the following officers for 1981-82: President-elect—Paul J Collopy, MD, Milwaukee; Secretary-Treasurer—Howard L Correll, MD, Arena; Ex-Officio Member of the Executive Committee—Thomas A Leonard, MD, Middleton. ■

WISCONSIN SENIOR PHYSICIANS CONVENTION—ATTENDEES, Saturday, October 17, 1981

Robin N Allin, MD, Madison
George H Anderson, MD, Stevens Point
D Murray Angevine, MD, Madison
John V Berger, Jr, MD, Madison
William D Brand, MD, Milwaukee
Gordon Brewer, MD, Racine
B I Brindley, MD, Madison
Benjamin H Brunkow, MD, Monroe
H Laurence Burdick, MD, Milton
C J Buscaglia, MD, New Berlin
Guy M Carlson, MD, Madison
Homer M Carter, MD, Madison
Kenneth Carter, MD, Beloit
E Frank Castaldo, MD, Laona
Norman M Clausen, MD, Mazomanie
Howard L Correll, MD, Arena
Eugene E Eckstam, MD, Monroe
Albert C Fisher, MD, La Crosse
John V Flannery, MD, Wausau
W A Gramowski, MD, Stevens Point
Farrell F Golden, MD, Madison
Horace J Hansen, MD, Sheboygan
Samuel B Harper, MD, Madison
L E Haushalter, MD, Brookfield
Stanley W Hollenbeck, MD, Milwaukee
J S Huebner, MD, Oshkosh
August Jurishica, MD, Milwaukee
Harold J Kief, MD, Rhinelander
Charles K Kincaid, MD, Madison
Howard Klopf, MD, Brookfield
Fred W Kundert, MD, Monroe
Randolph Kreul, MD, Racine
Francis P Larme, MD, New Holstein
Thomas A Leonard, MD, Middleton
Philip W Limberg, MD, Glenwood City
B Jack Longley, MD, Madison
Kenneth F Manz, MD, Neillsville
Kilian H Meyer, MD, Richland Center
Dwain Mings, MD, Monroe
Theodore J Nereim, MD, Mount Horeb
Eugene J Nordby, MD, Madison
W W Nordholm, MD, Stoughton
Russell S Pelton, MD, Ripon
Margaret Prouty, MD, Madison
Karver L Puestow, MD, Madison
M F Purdy, MD, Janesville
Joseph W Rastetter, MD, Wauwatosa
Michael F Ries, MD, Brownsville
William T Russell, MD, Sun Prairie
Etheldred L Schafer, MD, Madison
Harry L Schwartz, MD, Kenosha
Eugene E Skroch, MD, Madison
Robert Slater, MD, Stevens Point
Paul N Sowka, MD, Stevens Point
Arthur W Tacke, MD, Milwaukee
Robert L Waffle, MD, Fond du Lac
Kenneth J Winters, MD, Milwaukee ■

COMO briefed on national health insurance proposals

"There is *under*whelming support in Washington for Pro-Competition Legislation" or any other form of National Health Insurance laws.

That was the message delivered to last month's meeting of the Coalition of Medical Organizations (COMO) by Ross Rubin, legislative attorney for the AMA. Mr Ross briefed the Coalition on the current status of national healthcare proposals. The only proposal being discussed at the present is Pro-Competition Legislation.

Proponents of such a system (who include Budget Director David Stockman) believe such a system of national healthcare would open the market place to all healthcare providers. Presumably physicians, nurse practitioners, faith healers, and even chiropractors would all be competing against each other for a share of the public's healthcare dollar. Proponents of such legislation feel this type of open market place would act to lower healthcare costs.

More realistic proposals are in the wind for the Medicare and Medicaid systems. Mr Ross envisions Congress authorizing a voucher system for these two plans. Under the proposal the holders of vouchers would be free to purchase the medical insurance coverage of their choice. Presumably, this system would be less costly than the current Medicare and Medicaid programs. ■

Budget repair bill passes Legislature: Veto threat

Both houses of Wisconsin's Legislature finally passed a "budget repair" bill November 17 designed to adjust state expenditures in response to federal budget changes. The bill finally adopted made substantial changes in the original proposal offered by the Governor.

The State Medical Society of Wisconsin was on record as supporting the original bill offered by the Governor which would have reinstated outpatient psychotherapy when provided directly by a psychiatrist. The Legislature's bill removes all references to outpatient psychotherapy except when it is provided by a 51.42 Board facility or by psychiatrists under contract with those Boards. In addition, counties must provide 10% of the funding for the service under the plan adopted by both houses.

Unless the entire bill is vetoed by Governor Dreyfus, it appears that outpatient psychotherapy will be eliminated from the Title 19 program. A complete veto is possible although the major disagreement between the Governor and the legislative Democrats is over shared revenue payments to local units of government. The SMS Committee on Mental Health and the Physicians Alliance Commission will be reviewing this situation and will recommend options for further action to the SMS Board of Directors. ■

SMS-endorsed malpractice bill advances

A bill developed with input from the Society's Medical Liability Committee which would revise the procedures of the Patients Compensation Panels has passed the Assembly.

Before passing Assembly Bill 537 by a 96-0 vote, the Assembly tacked on several amendments to the measure. While most of the changes are technical in nature, two make substantial changes in the bill.

One amendment sets reimbursement to all panel members at $125 per panel meeting. Under current law, panel members are paid $75 per meeting and AB 537 would have increased the reimbursement of physicians and attorneys to $150.

Another amendment allows parties in a panel action to replace a panel chairman by use of a peremptory (cause need not be shown) challenge. As originally introduced, AB 537 required that good cause be shown when requesting replacement of a panel chairman.

Despite these changes, SMS remains supportive of the AB 537 and will seek favorable action in the Senate. ■

State Attorney General pushes strong formaldehyde standard

Wisconsin's Attorney General has urged the US Department of Housing and Urban Development (HUD) to adopt a strict standard for formaldehyde emissions in mobile homes. In a letter to HUD in November, Atty Gen Bronson LaFollette cited a recommendation of the State Medical Society's Committee on Environmental and Occupational Health to adopt a standard of no more than 0.1 parts per million. The State Department of Industry, Labor and Human Relations earlier this year had adopted an administrative rule which was to have gone into effect in September 1981 setting formaldehyde vapor limits in mobile homes at 0.4 ppm. The Dane County Circuit Court has issued a temporary restraining order preventing DILHR from enforcing the rule until January 4 when a court hearing will be held on a suit filed against the Department by the Manufactured Housing Institute. ■

GAC takes positions on new legislation

The SMS Governmental Affairs Commission met at SMS offices November 11 and took positions on the following pieces of new legislation:

• **Immunization for mumps—SB 578:** Would include mumps in the immunization program for school-age children. Current law requires all children, nursery school through grade 12, to be immunized for measles, rubella, diphtheria, pertussis, polio, and tetanus, except where exemptions are granted for medical, religious, or personal conviction reasons. *SMS supports.*

• **Chiropractic coverage—SB 603:** Requires all group health cooperatives, voluntary sickness care plans, and health insurance policies to provide coverage for services performed by a chiropractor, if the plan or policy covers those services when performed by a physician. *SMS opposes.*

• **Public patient treatment—SB 583:** Allows county hospitals, or private hospitals under contract with counties, to treat public patients and to bill the state for 50% of the net cost. Current law allows for 50% state reimbursement for public patient treatment only if the patient is treated at University of Wisconsin Hospital and Clinics. *SMS supports.*

• **Hospital rate review—AB 822 & SB 605:** Repeals Wisconsin's Rate Review Program and allows the Department of Health and Social Services to prospectively set rates on its own. The bill also contains a provision for typing-in certificate-of-need with the rate-setting procedure. *SMS opposes,* on the grounds of total state takeover and the inadequately defined CON procedure.

• **Administration of drugs by school personnel—AB 728:** Allows a school district administrator or school principal to designate a school employee or volunteer to administer medications to pupils in compliance with written instructions of a physician, dentist, or podiatrist, if the pupil's parent or guardian consents in writing. *SMS supports.* ■

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Milwaukee Society to install new radio paging system

The Medical Society of Milwaukee County Board of Directors voted unanimously in November to negotiate for and install a wide-area radio paging system. Among the system's benefits will be a reduction in message transmission time from the current 15 seconds per message to 1/6th of a second per message. The system increases efficiency and versatility while reducing costs to subscribers. The projected date for operational installation is midsummer, 1982.

WINNEBAGO: Forty-five members and five guests were present at the November meeting of the Winnebago County Medical Society to hear Russell F Lewis, MD,* Marshfield, and Darold A Treffert, MD,* Fond du Lac, speak on various items of political interest as they relate to the state and county medical societies. Doctor Lewis is immediate past president of the State Medical Society and Doctor Treffert is chairman of the SMS Board of Directors. Also answering questions and speaking on political issues relating to medicine were Timothy T Flaherty, MD,* Neenah, member of the SMS Board of Directors from the Fifth District, and Kenneth M Viste Jr, MD,* Oshkosh, chairman of the SMS Physicians Alliance Commission.

ROCK: The Rock County Medical Society had as its speaker for the September meeting, Dr Robert Seymour, medical officer of the Rock County Board of Health. He spoke on the duties and the general aims of the Rock County Board of Health.

MANITOWOC: Manitowoc County Medical Society recently honored Walter F Smejkal, MD,* for his more than 30 years of service to the Manitowoc community. Doctor Smejkal graduated from the University of Illinois College of Medicine and joined the medical staff of Holy Family Hospital in 1951. He has served as chief-of-staff of the hospital; Civil Defense director; the Manitowoc County Highway Safety Commission; Manitowoc County Emergency Medical Commission, and recently was appointed deputy coroner.

DANE: At its Annual Meeting October 6 in Madison the Dane County Medical Society members elected the following officers: president—Sandra L Osborn, MD,* Madison; vice president—James P Speichinger, MD,* Madison; and secretary-treasurer—Richard D Lindgren, MD,* Madison. Also elected as members-at-large on the Board of Trustees were: John J Ouellette, MD,* Madison; and Martin B Fliegel, MD,* Madison. Other activities at the Annual Meeting included a presentation on the status of delivery of ambulance services in Dane County, acceptance of the 1981 HMP Guidelines for Dane County for 1982, and a presentation of socioeconomic issues facing medicine in the near future, including uniform fees and consideration of new methods of health services delivery under Medicaid; chiropractic legislation; and status of psychiatrists as physicians.

Newly elected members: Jeffrey D Davis, MD,* 30 S Henry St, Madison 53703 (gastroenterology/internal medicine); Barbara L Loevinger, MD,* 5002 Sheboygan Ave, Madison 53705 (psychiatry); Timothy P Russell, MD,* 304 N Bristol St, Sun Prairie 53590 (family practice); Vanee Songsiridej, MD,* 600 Highland Ave, UW-Madison CSC, Madison 53792 (internal medicine/allergy); John M Strohm, MD,* Apt 5, 6315 Century Ave, Middleton 53562 (anesthesiology); Bruce E Weffenstette, MD,* N77 W5411 Bywater Lane, Cedarburg 53012 (psychiatry); Michael A Weiner, MD,* Suite A, 5520 Medical Circle, Madison 53711 (plastic surgery); and Samuel C Shih, MD,* 36 S Brooks St, Madison 53715 (clinical pathology/nuclear medicine).

Members and spouses of the DCMS held a personal financial planning seminar November 11 at the Concourse Hotel in Madison. Thomas L Carter, MD* was chairman of the program committee. Topics and speakers included: *Life and disability insurance,* by Neal H Brunner, personal insurance consultant, Employee Benefit Plans, Inc, Madison; *Real estate: Commodity speculation or capital asset?,* by James A Graaskamp, PhD, chairman, Dept Real Estate & Urban Land Economics, UW School of Business; founder and president, Landmark Research, Inc; *Estate planning in transition under the '81 Act,* by Attorneys Donald R Huggett and Frederic J Brouner, DeWitt, Sundby, Huggett and Schumacher, SC, Madison; and *Investment issues for the 1980s,* by Stephen Hawk, PhD, professor of finance, UW Graduate School of Business, and principal, Northern Capital Management, Inc. The afternoon session was followed by an evening dinner.

MILWAUKEE: Newly elected members: Luciano R Beltran, MD,* 620 N 19th St, Milwaukee 53233 (family practice); James A Duncavage, MD,* 8700 W Wisconsin Ave, Milwaukee 53226 (otolaryngology); Timothy R Hess, MD,* 3070 N 51st St, Suite 601, Milwaukee 53210 (cardiology/internal medicine); Nicholas A Kozlov, MD,* 728 N Jefferson St, Milwaukee 53202 (gastroenterology/internal medicine); Betty J Maly, MD,* 9001 W Watertown Plank Rd, Milwaukee 53226 (physical medicine and rehabilitation/child psychiatry); John C Pastorius, MD,* 2331 W Vieau Pl, Milwaukee 53204 (family practice); Larry C Pearson, MD,* 6541 N Braeburn Lane, Glendale, 53209 (internal medicine/rheumatology); Michael S Reid, MD,* 2040 W Wisconsin Ave, Milwaukee (cardiology/internal medicine); Mohammad Shenasa, MD,* 950 N 12th St, Milwaukee 53233 (internal medicine/cardiology); Barry G Siegel, MD,* 4067 W Lake Dr, Shorewood 53211 (psychiatry); David A Slosky, MD,* 2315 W Lake Dr, Milwaukee (cardiology/internal medicine); Dilipkumer B Subbarao, MD,* 100 15th Ave, South Milwaukee (internal medicine). ■

Obituaries

Richard H Siedenburg, MD, 63, Jefferson, died Sept 23, 1981 in Jefferson. Born July 19, 1918 in Queens, New York, Doctor Siedenburg graduated from St Louis University School of Medicine and served his internship at Kings County Hospital, New York, NY. His residency was completed at the Mayo Clinic in Rochester, Minn. Prior to moving to Jefferson, Doctor Siedenburg was a physician for Standard Oil Company in New York. He was named Jefferson County Handicapped Person of the Year in 1969 and in 1979 he became a fellow in the American Academy of Family Physicians. He was a member and past president of the Jefferson County Medical Society, a member of the State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Melba; a son, Richard, Lake Mills; and four daughters, Mrs Dean (Susan) Laesch, Fort Worth, Tx; Sandra and Karen, Jefferson; and Kirsten, at home.

Joseph S Devitt, MD, 68, Whitefish Bay, died Oct 10, 1981 in Milwaukee. Born Sept 22, 1913 in Milwaukee, Doctor Devitt graduated from Marquette University School of Medicine and served his internship and residency at Milwaukee County General Hospital. He served for many years on the SMS Commission on Public Relations and Communication. He also served as chief-of-staff of St Mary's Hospital, Milwaukee; was an associate clinical professor in the Department of Family Practice at the Medical College of Wisconsin and has been instrumental in the development of the family practice residency program at St Mary's Hospital in Milwaukee. He served as president of the Medical Society of Milwaukee County and the Wisconsin Academy of Family Physicians. Surviving are his widow, Doris; five sons, Michael, Shorewood; Patrick, Janesville; Timothy, Soldiers Grove; Terrance, Madison; Dennis, Whitefish Bay; and four daughters, Mrs Gonzalo (Kathleen) de las Heras, Madrid, Spain; Mary, Milwaukee; Mrs H James (Margaret) Katz, Milwaukee, and Anne of Milwaukee.

The family has suggested contributions be made to the Joseph S Devitt, MD Memorial Fund, care of Family Practice Department, St Mary's Hospital, 2323 N Lake Dr, Milwaukee, Wis 53211.

John F Moon, MD, 81, former Baraboo physician, died in October 1981 in Mesa, Calif. Born Feb 28, 1900 in Ashland, Doctor Moon graduated from the University of Illinois Medical School and served his internship at Methodist Hospital in Madison. Doctor Moon had practiced medicine in Baraboo for 35 years before moving to Mesa, Calif in 1958. Surviving are his widow, Virginia, and two sons.

James L Born, MD, 66, formerly of Madison, died Oct 17, 1981 in Madison. He graduated with a law degree from the University of Wisconsin, Madison, and served as acting assistant attorney general of Wisconsin from 1942-1944. In 1948 he graduated from the University of Wisconsin Medical School, Madison, and moved to California. In California he was associated with the Donner Laboratory and since 1976 had been the director of medical research on cancer and various blood disorders at the University of California-Berkeley Donner Laboratory.

Delbert P Nachazel, Jr, MD, 48, Royal Oaks, Mich, died Oct 18, 1981 in Royal Oaks. Born Sept 24, 1933 in Milwaukee, Doctor Nachazel graduated from Marquette University School of Medicine in 1958 and served his internship at St Joseph's Hospital in Milwaukee. His residency was completed at the Illinois Eye and Ear Infirmary and the Massachusetts Eye and Ear Infirmary in Boston. Doctor Nachazel practiced medicine in Waukesha until moving to Michigan in 1970. Surviving are his widow, Marlene; and four children.

James H Turner, MD, 50, Middleton, died Oct 19, 1981 in Madison. Born in Glasgow, Scotland on Sept 3, 1931, he graduated from the University of Edinburgh in 1959 where he also served his internship. He was a pathologist on the medical staff of the William S Middleton Memorial Veterans Administration Hospital in Madison. Surviving are his widow, Patricia, and a son, David.

Thaddeus B Lorenty, MD, 69, Chicog Township near Spooner, died Oct 22, 1981. Born Nov 4, 1911 in Chicago, Ill, Doctor Lorenty graduated from Loyola University School of Medicine, Chicago, and served his internship at St Mary Mercy Hospital in Gary, Ind. After practicing medicine for 35 years in Gary, Doctor Lorenty moved to Minong, Wis. He was on the medical staff of Spooner Community Memorial Hospital. Surviving are his widow, one son, and five daughters.

Mark E Nesbit, MD, 83, Madison, died Oct 22, 1981 in Madison. Born July 8, 1898 in LaPorte City, Ia, Doctor Nesbit graduated from the University of Pennsylvania School of Medicine in 1926 and served his internship at Ceisinger Hospital, Danville, Pa. His residency, in ophthalmology, was completed at the Mayo Clinic in Rochester, Minn. He was a member of the Mayo Clinic Alumni and also was a "Distinguished Senior Alumnus" of the University of Pennsylvania School of Medicine. Doctor Nesbit was a membr of the "Fifty Year Club" of the State Medical Society of Wisconsin, a member of the Dane County Medical Society, and of the American Medical Association. Surviving are his widow, Blanche; and a son, Dr Mark, a professor of pediatrics at the University of Minnesota Hospitals in Minneapolis.

Lloyd M Simonson, MD, 73, Sheboygan, died Oct 22, 1981 in Sheboygan. Born Mar 9, 1908 in Deerfield, Doctor Simonson graduated from the University of Wisconsin Medical School, Madison, and served his internship and residency at University Hospital, Ann Arbor, Mich, and the University of Wisconsin Hospital, Madison. Doctor Simonson had been a member of the

medical staff of the Sheboygan Clinic until his retirement in 1974. He had been a member of the State Medical Society of Wisconsin's Commission on State Departments, a member of Sheboygan County Medical Society and the American Medical Association. Surviving are his widow, Frances; a daughter, Mrs Daniel (Karen) Boerger, Racine; and a son, Dr Rolf of Sheboygan.

John A Thranow, MD, 77, La Belle, Florida, died Oct 24, 1981 in Fort Myers, Florida. Born Feb 17, 1904 in Milwaukee, Doctor Thranow graduated from Marquette University School of Medicine in 1928 and served his internship at Deaconess Hospital, Milwaukee. Doctor Thranow practiced medicine in Milwaukee until moving to Florida in 1967. He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and the American Medical Association. Surviving are his widow, Josephine; one son, John A Thranow Jr, MD of Valders; and two daughters, Mrs James D (Catherine) Porter, Brooklyn Heights, NY, and Mrs R Craig (Elizabeth) Campbell of Scottsdale, Arizona.

Edward Carl Schmidt, MD, 66, Shorewood, died Oct 26, 1981 in Milwaukee. Born Jan 14, 1915 in Milwaukee, Doctor Schmidt graduated from the University of Wisconsin Medial School, Madison, in 1940. His internship was served at Milwaukee County General Hospital and his residency was completed at Milwaukee Psychiatric Hospital and the Mayo Clinic, Rochester, Minn. Doctor Schmidt had served on the Committee on Alcoholism and Other Drug Abuse of the State Medical Society of Wisconsin. He was a member of the medical staff of Good Samaritan Medical Center and Columbia Hospital in Milwaukee. He was a member of the Wisconsin Psychiatric Association, Milwaukee Neuro-Psychiatric Society, the Medical Society of Milwaukee County, and the American Medical Association. Doctor Schmidt was a Life Fellow of the American Psychiatric Association. Surviving are his widow, Lois; a son, Eric; and two daughters, Laurie Simons, and Gretchen Grzelak. ■

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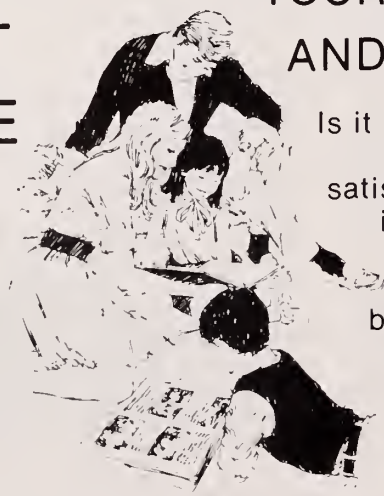

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Physician Briefs

*Physician members of State Medical Society of Wisconsin

Richard Sazama, MD, recently became a member of the medical staff of St Joseph's Hospital, Chippewa Falls. Associated in medical practice with MDs Thomas J Doyle, Jr* and David J Katz,* Doctor Sazama graduated from the University of Wisconsin Medical School, Madison. His residency in urology was completed at the University of Minnesota Hospital, Minneapolis.

Vishwanath Negale, MD, Monroe, recently became associated with The Monroe Clinic in the Department of Urology. Doctor Negale graduated from T N Medical College, Bombay, India, and was in family practice for seven years. He also completed postgraduate work in general surgery. In 1974, Doctor Negale arrived in this country and completed a five-year residency at Cook County Hospital, Chicago. He also spent a year as a fellow in urologic oncology research and pediatric urology in Montreal Children's Hospital.

Cynthiane Morgenweck, MD,* Sheboygan, has joined the Department of Anesthesiology at St Nicholas Hospital, Sheboygan. She graduated from the Medical College of Wisconsin, Milwaukee, and completed her residency at the University of Texas Medical Branch, Galveston, the Medical College of Wisconsin, and the University of Texas Health Science Center in Houston. Doctor Morgenweck is a member of the American Society of Anesthesiologists and the International Anesthesia Research Society.

Thomas R Connell, MD, Sheboygan, recently became associated with the medical staff of St Nicholas Hospital in Sheboygan. Doctor Connell graduated from the Medical College of Wisconsin, Milwaukee, and completed his residency in radiology at the Mayo Clinic, Rochester, Minn. He is certified by the American Board of Radiology.

Victoria A Vollrath, MD,* Madison, recently opened her medical practice in Madison. Doctor Vollrath graduated from the Medical College of Wisconsin in Milwaukee and served her family practice residency in Waukesha. She has served as an assistant professor, Department of Family Practice, Medical College of Wisconsin, and as associate director of the Waukesha Family Practice Residency Program at Waukesha Memorial Hospital.

Indira Mammen, MD, Mequon, recently opened her medical practice in Port Washington. She graduated from Trivandrum Medical School, India, and completed her residency program at Mount Sinai Medical Center in Milwaukee. She is on the medical staff of St Alphonsus Hospital, Port Washington, and Mount Sinai Medical Center, and St Michael Hospital in Milwaukee.

Roger G Klettke, MD,* Oostburg, recently joined the medical staff of St Nicholas Hospital in Sheboygan. A graduate from the University of Michigan Medical School in Ann Arbor, Doctor Klettke completed an internship and residency at Bronson Methodist Hospital in Kalamazoo, Mich. A member of the American College of Pathologists and the American Society of Clinical Pathologists, Doctor Klettke served a fellowship in electron microscopy at Beaumont Hospital in Royal Oak, Mich, prior to coming to Sheboygan.

Martin L Janssen, MD,* Friendship, recently was reelected to a three-year term as a director for the Wisconsin Academy of Family Physicians. He also was reelected as chairman of the Professional and Public Policy Committee of the Academy. Doctor Janssen is a member of the State Medical Society's Commission on Governmental Affairs.

N Carter Noble, MD, Appleton, recently became associated with the Stockbridge Health Center. He joined Robert D Heinen, MD,* and William J Carlson, MD, at the Center. Doctor Noble graduated from the University of Wisconsin Medical School, Madison, and served his family practice residency in Eau Claire. He practiced for two years in Darlington before joining the Stockbridge Health Center which is a satellite clinic of the Medical Arts Clinic in Appleton.

James F Guhl, MD,* Milwaukee, recently was named vice president of The Arthroscopy Association of North America. He also was reappointed to the Board of Directors of the International Arthroscopy Association. Doctor Guhl is a faculty member of the Medical College of Wisconsin, a member of the American Orthopaedic Society for Sports Medicine, and the American Academy of Orthopaedic Surgeons.

Doctor Guhl

Lynn J Seward, MD,* Berlin, is shown above receiving the first annual Human Service Award from Mrs Debra Johanknecht, president of the Berlin Hospital Association Auxiliary, while his wife, Mrs Gladys Seward (left) and Miss Grace Wilson, Fond du Lac, look on. The plaque will hang in the hospital near the volunteer desk. (Photo courtesy of Jim Wolff, *Berlin Journal*)

CORRECTION. In the September 1981 issue, page 52, the Journal erred in the photograph of Dr Daniel McCarty. The photograph appearing in the article is that of Dr Robert K Gleeson who recently joined the Northwestern Mutual Life Insurance Co, Milwaukee, as assistant medical director. Doctor McCarty's photograph appears here. The Journal regrets this error and extends its apologies to the two doctors. The article also failed to indicate that Doctor McCarty is a member of the State Medical Society of Wisconsin.

Doctor McCarty

Robert E Jordon, MD,* Elm Grove, recently was appointed chairman of the American Academy of Dermatology Foundation's Medical and Scientific Committee. A professor of medicine and chief of dermatology at the Medical College of Wisconsin, Milwaukee, Doctor Jordon is on the staff at Milwaukee County Medical Complex and the Veterans Administration Medical Center, Wood.

Bruce Weffenstette, MD,* formerly of Madison, has accepted an appointment to the medical staff of the Washington County Mental Health Center. A native of Indiana, he graduated from Indiana University School of Medicine and completed a four-year residency program at the University of Wisconsin, Madison. He previously had served as a staff physician for the Dane County Mental Health Center Detoxification Unit.

Robert L Gilbert, MD,* LaCrosse, recently retired from his medical practice with the Skemp-Grandview-LaCrosse Clinic. He was instrumental in the mergers of the Skemp, Grandview, and LaCrosse clinics. Doctor Gilbert was chief-of-staff at Saint Francis Medical Center in 1977, and also aided in establishing the Coronary Intensive Care Unit at the Center. He served on the Board of Directors of the American Society of Internal Medicine and also was president in 1957. In 1967 he was president of the LaCrosse County Medical Society and in 1979 was awarded the Max Fox Preceptorship Award by the University of Wisconsin Medical School, Madison.

Doctor Gilbert

Mark O Weisse, MD, Algoma, recently became associated with Jack F March, MD* at the Algoma Clinic. Doctor Weisse graduated from the University of Wisconsin Medical School, Madison, and completed his family practice residency at Waukesha and with the United States Air Force in Louisiana.

Jack L Ziemer, MD, Ladysmith, has joined the medical staff of the Marshfield Clinic and its Ladysmith Center facility. Doctor Ziemer graduated from the University of Wisconsin Medical School, Madison, and completed his internship and residency at McKennan Hospital in Sioux Falls, SD. Postgraduate training also was completed at Sioux Valley Hospital and the Veterans Administration Hospital in Sioux Falls, SD. ■

AMA Physician's Recognition Award Recipients

LISTED BELOW are those physicians in Wisconsin who have earned the AMA Physician's Recognition Award in recent months. The award was established in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians." A minimum of 150 credit hours of CME must be earned over a three-year period to qualify for the award. The hours may include such activities as conferences, residencies, teaching, writing, private reading, listening to cassettes, home study courses, consultation, and peer review; at least 60 of the hours, however, must be from formal CME programs sponsored or cosponsored by organizations accredited for these activities. The State Medical Society of Wisconsin congratulates the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

OCTOBER 1981

*Bock, Harvey M, Milwaukee
*Brei, Frederick A, Appleton
*Burr, Thurl C, Wausau
*Crawford, Chester W, Green Bay
*Effenhauser, Manfred, Lake Mills
Funahashi, Akira, Wood
*Galgano, Rocco S, Delavan
*Garman, John S, Waterloo
*Henney, Thomas E, Portage
Herman, Bruce C, Thiensville
Johnson, Edward J, Green Bay
*Jordan, John C, Richland Center
*Kabler, J D, Madison
*Kashnig, David M, Milwaukee
*Kaunas, Roman, Milwaukee
*Kelly, John J, Milwaukee
*King-Kubiak, Mary K, Neenah
*Kocovsky, Clarence J, Milwaukee
Lam, Anselm On-Sang, Brown Deer
*Lantis, Larry R, Madison
*Melamed, Abraham, Milwaukee
*Melms, Frederick A, Menomonie
*Mintz, Stephan M, Milwaukee
*Mortimore, Robert H, Reedsburg
*Narins, Voldemars, Rice Lake
*Natoli, Cornelius A, La Crosse
*Rattan, Walter C, Kenosha
*Rolnick, David J, Madison
*Schmidt, Daniel K, Mequon
*Shenefelt, Philip D, Madison
*Smalley, John J, La Crosse
*Starr, Robert A, Viroqua
*Tange, David B, Mosinee
Varona, Rose T, Brown Deer
*Warrick, James D, Madison
*Watts, Alice D, Oregon ■

*Members of the State Medical Society of Wisconsin

News Highlights

*Physician members of State Medical Society of Wisconsin

St Mary's Hospital, Milwaukee, recently named Jon Wachs its associate administrator. As associate administrator, he will direct the administrative activities of St Mary's Hospital and he will serve under the hospital's chief executive officer Sister Julie Hanser, DC. Mr Machs was previously national director of healthcare consulting for Meidinger, Inc of Milwaukee; was a consultant in the management services group of Arthur Young and Co and personnel director at St Lukes Hospital. He also was an assistant professor of health administration education for the University of Wisconsin-Extension, in Madison and Milwaukee.

American Heart Association of Wisconsin recently elected two new officers and installed a new president at the annual meeting held in Milwaukee on October 23, 1981. George G Griese, MD,* pediatric cardiologist at the Marshfield Clinic assumed the presidency, succeeding James F King, MD* of Milwaukee. Michael H Keelan, MD, Milwaukee, was elected to the post of president-elect, and Daniel F Carlton, vice president of budget and finance at St Luke's Hospital, Milwaukee, was elected treasurer. Doctor Griese has been a member of the association since 1958 and is director of the Comprehensive Child Care Center at the Marshfield Clinic; and Doctor Keelan is professor of Medicine at the Medical College of Wisconsin, Milwaukee, and also is the recipient of the Association's 1981 "Outstanding Physician Award."

University of Wisconsin Hospital and Clinics are featuring an exhibit Dec 3 through Dec 29 in the Skylounge Gallery (C5/2) at 600 Highland Ave, Madison. "Medicine Men," a series of color lithographs by John L Doyle, is a traveling exhibition that will be shown at major medical centers in the Midwest and Eastern US including the Mayo Clinic, Harvard, and Johns Hopkins. The portfolio depicts ten of mankind's mystical healers, from Tibetan sorcerer to African witchdoctor. Each work is accompanied by a cultural history written by Doyle. The "Medicine Men" lithographs are part of a larger series on "The Great Human Race." Works by Doyle have been exhibited at the Smithsonian Institute, the Library of Congress, and the Art Institute of Chicago. The UW showing is sponsored by Midwest Medical, Inc, of Afton, Minn. ■

Specialty Societies

*Physician members of State Medical Society of Wisconsin

American Congress of Rehabilitation Medicine has announced the appointment of John L Melvin, MD,* Milwaukee, to its Board of Governors. Doctor Melvin, professor and chairman of the Department of Physical Medicine and Rehabilitation, The Medical College of Wisconsin, Milwaukee, was named fifth vice president of the Congress. He graduated from Ohio State University College of Medicine in 1960 and has been a member of the faculty of The Medical College of Wisconsin since 1973.

American College of Surgeons, 67th Annual Clinical Congress, recently was held in San Francisco. The following Wisconsin physicians participated in the program: Robert E Condon,* John J Gleysteen, W D Foley, T L Lawson, G F Unger, Ruedi P Gingrass, Joseph C Darin, Stuart D Wilson,* Konrad Soergel, Frank E Jones, Richard A Komorowski* of Milwaukee; Don G Traul,* Monroe; David G Dibbell,* Richard K Dortzbach,* Allan B Levin,* Hans W Sollinger, Reginald C Bruskewitz, Peter Iversen, and Paul O Madsen, Madison. The scientific exhibit entitled "Coronary Endarterectomy: Surgical Treatment of Severe Diffuse Coronary Artery Disease" was shown by W Dudley Johnson, MD,* Pablo M Pedrazza, MD,* and Kenneth L Kayser, MD of Milwaukee. The Board of Governors listed on the program includes three Wisconsin MDs: Wayne J Boulanger* and Bruce J Brewer* of Milwaukee, and Richard O Schultz, MD,* Elm Grove. ■

'GUIDELINES FOR DETERMINATION OF DEATH' PUBLISHED. "Guidelines for the Determination of Death," part of a report from the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, has been published in the *Journal of the American Medical Association* (Nov. 13, 1981). The document is a summary of currently accepted medical practices for the determination of death, both cardiorespiratory and neurological (brain death). The criteria take into consideration new technologies in the laboratory confirmation of the diagnosis of death, and are the first update of standards for brain death since 1968. ■

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RATES: 40¢ per word, with a minimum charge of $16.00 per ad. BOXED AD RATES: $32.00 per column inch. DEADLINE: Copy must be received by the 20th of the month preceding month of issue; e.g., copy for the August issue is due July 20. Send copy to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080.

Physicians Exchange

Experienced Emergency Physician sought for four-man group, Southeastern Wisconsin. Annual visits 24,000. Modern facility with full specialty back-up. Equal sharing shifts. Fee for service. 90 K per annum. Emergency experience desirable. ACLS. Send CV or call R J Krill, MD, 3801 Spring St, Racine, Wis 53405; ph 414/636-4011. 11-12/81

Oncologist needed to join the only two oncologists in the community working within a multispecialty group of 22 physicians at the Racine Medical Clinic. The Clinic is a progressive organization offering a competitive salary for the first 18 months with a full ownership thereafter and a full fringe benefit package. Contact R D Lacock, Racine Medical Clinic, 5625 Washington Ave, Racine, Wis; ph 414/886-5000. 10 tfn/81

General Surgeon. Board eligible/certified to join primary care group of six family physicians. Well established, rural setting, preceptor University of Wisconsin, JCAH 70-bed hospital. Send CV to: Gary Petersen, MD, Krohn Clinic, Ltd, 610 W Adams St, Black River Falls, Wis 54615. 10 tfn/81

Dermatologist, Rheumatologist, Oncologist needed to join multispecialty group of 33 physicians dedicated to primary care in East Central Wisconsin community. City population 48,000, drawing area 100,000. Attractive income arrangements, association membership possible after one year, pension and profit sharing, extensive fringe benefits. Contact: R B Windsor, MD, 1011 North 8th St, Sheboygan, Wis 53081; ph 414/457-4461. 12tfn/81

Neurologist, Allergist, Cardiac Surgeon, Nephrologist, Psychiatrist. Opportunities in small group private practice. Tertiary referral center with active teaching program and fully equipped hospital including advanced lab facilities, CT scanner, oncology program, cath lab, cardiac surgery, neurosurgery, dialysis, etc. Service area 300,000 plus. Unspoiled university city on Lake Superior offers outstanding recreational opportunities. Contact: J D Wojcik, MD, Chairman, Recruitment Committee, Marquette General Hospital, Marquette, Mich. 49855; ph 906/228-9449, ext. 434. 10-12/81

PRIMARY CARE PHYSICIANS
BOARD CERTIFIED OR ELIGIBLE

We represent over 50 communities throughout the state which are seeking quality primary care physicians. These communities offer established service areas, generous practice and financial arrangements.

CONTACT:
Laurie Glowac or Fred Moskol
New Physicians for Wisconsin
University of Wisconsin Department of Family Medicine
777 South Mills Street, Madison, Wisconsin 53715
Phone: 608/263-4095
p1-12/81

Internist wanted to join a 14-physician multispecialty group in one of northern Wisconsin's finest recreation areas. Modern 109-bed hospital. Excellent professional and personal opportunity. Contact Dr J Wiesner, Lakeland Medical Associates Ltd, Box 549, Woodruff, Wis 54568 or call 715/356-3292. 5tfn/81

Medical Ophthalmologist wanted to join established, growing practice in beautiful Lake Tahoe-Reno, Nevada area. Excellent climate and year-round recreational facilities. Will consider full or part-time or retired physician. Contact Karen Grodowitz, MS, Executive Director, Reno Eye Clinic, 1530 E 6th St, Reno, Nev 89512; ph 702/329-1389. 10 tfn/81

OB-GYN teaching coordinator at Truman Medical Center/East, one of two teaching hospitals for the University of Missouri-Kansas City School of Medicine. Joint faculty appointments in Departments of Family Medicine and OB-GYN. Primary responsibilities teaching OB and office GYN to Family Practice residents, supervision of, and work with, a 4th-year OB-GYN resident, some lesser involvement with medical students, and consultation in high-risk pregnancy problems as they present. Competitive salary, excellent fringes, opportunities for additional practice if desired. Contact Familv Medicine Department, University of Missouri-Kansas City School of Medicine, Truman Medical Center/East, Route 17, Kansas City, MO 64139; ph 816/373-8210. Attention: Thomas A Nicholas, MD, Chairman, or Robert E Stelle, MD, Vice-chairman. 12/81*

Family Practice available. Located 2 minutes from Elmbrook Hospital in suburban Brookfield, expense-sharing situation available in fully equipped office with Donald L Wood, MD. Contact J D Rienstra, MD; ph 414/786-5534. 12/81

Physician wanted to share fully equipped medical office, x-ray, lab, fully staffed, small community, northern Wisconsin. Contact Dept 496 in care of the Journal. 12tfn/81

Emergency Physicians. Full-time openings for ER physicians with group serving hospitals in Manitowoc, Sheboygan, Wisconsin Rapids, Shawano, Oconto Falls, and other cities. Excellent starting salaries, flexible schedules. Must be willing to relocate to area. Send CV to: Central States Emergency Physicians, PC, 1846 Hoffman St, Suite 101, Madison, Wis 53704 or ph 1/800-362-7366. 7-12/81

Surgeon with Thoracic general vascular training and Ophthalmologist to join a progressive multispecialty group of 17 physicians consisting of General/Family Medicine, General Surgery, Internal Medicine, OB-GYN, Ophthalmology, Orthopaedic Surgeon, Pediatrics/Adolescent Medicine, and Radiology. Subspecialties include: Pathology, Vascular Surgery, Cardiovascular Diseases, Gastroenterology and Endoscopy. We are located in a fast growing, scenic, lake country area between Milwaukee and Madison and can offer excellent hospital, schools and recreational facilities. Full fringe benefit package. Contact: James F Dowd, Admin, Wilkinson Clinic, SC, 915 East Summit Ave, Oconomowoc, Wis 53066; ph 414/567-4433. 9tfn/81

Physicians Exchange

continued

Wausau Medical Center, SC, a 50-physician multispecialty group has openings for physicians in the following specialties. *Family Practice, Hematology/Oncology, Neurology* and *Otolaryngology.* Competitive first-year salary, incentive plan thereafter. Comprehensive fringe benefits. New facility near new hospital. Located in beautiful, quiet, central Wisconsin, metropolitan area of 65,000. Recreational opportunities abundant. For more information contact: K L Day, MD, Wausau Medical Center, SC, 2727 Plaza Drive, Wausau, Wis 54401, or call collect 715/847-3351. 7tfn/81

Neurologist to join a three member neurology/neurosurgery group in Waukesha County. Negotiable salary with potential for full partnership after one year. Contact: James C Hanson, MD, Neurologic Associates of Waukesha Ltd, 1111 Delafield St, Waukesha, Wis 53186. p9-11/81

Physician wanted to perform light physicals on a full or part-time basis. Ideal job for retiring physician. Contact Mike Stough collect at 513/621-8728. 10 tfn/81

Internist with or without a subspecialty, wanted to join Milwaukee Internal Medicine Group. First-year salary negotiable. Opportunity to join corporation. Excellent fringe benefits and retirement plan. Contact: Administrator, Cathedral Square Medical, SC, 525 E Wells St, Milwaukee, Wis 53202. 11-12/81

Professional FP Locum Tenens available. Board certified family practice. Wide range of experience including OB and ER. Prefer 1-2 week periods. $1800 per week plus room and travel. Write 5695 Mary Lane, Excelsior, Minn 55331; ph 612/474-4372. 11-12/81; 1/82

Wanted. Board certified or eligible orthopedic surgeon to practice in conjunction with a 5-member surgery department in a 22-member multispecialty group. Present surgical specialties: thoracic and vascular surgery, general surgery and urology. The group is located in the upper midwest, in a city of 100,000 between two major metropolitan areas of greater than one million. If interested, please send CV to: Stephen Wagner, Kurten Medical Group, SC, 2405 Northwestern Ave, Racine, Wis 53404. All inquiries will be kept confidential. 12tfn/80

Family Practice immediate opening. Join 22-physician multispecialty group in Appleton, Wisconsin. Excellent hospitals, guarantee plus incentive compensation. Complete benefit package. Medium-size community. Contact Art Schuetze, Administrator, Medical Arts Clinic, SC, 401 N Oneida St, Appleton, Wis 54911; ph 414/739-0171. 11-12/81; 1/82

Immediate opening for General and Child Psychiatrist to join well-established clinic in a community of 50,000. Large referral area. Two excellent hospitals. University and industrial area. Salary open. Excellent benefits. Contact: J M Tobin, MD, Northwest Psychiatric Clinic, Box 224, Eau Claire, Wis 54701; ph 715/834-2751. 12/81; 1-3/82

PUT EXPERIENCE TO WORK FOR YOU WHILE YOU SEARCH FOR A NEW CHALLENGE

Let years of experience as a healthcare professional and a Placement Counselor assist you in finding a new location with a new challenge. Physicians in all specialties are urgently needed throughout the country. Many types of situations available. Confidentiality assured.

Contact Donna Herschleb, RN
MEDICAL PROFESSIONAL PLACEMENTS
5222 Painted Post Drive, Madison, Wisconsin 53716
Phone: (608) 222-2927 *Licensed Employment Agency*

Internist/Generalist/Family Practitioner: Position available in 300-bed active psychiatric rural hospital. Fully JCAH accredited. Three-year Psychiatric Residency Program. All treatment modalities. Numerous affiliated educational programs. Near metropolitan and recreational areas. Relaxed, low crime, low turmoil area. Salary range $47,902-$58,282 depending upon qualifications. Good fringe package and possibility of some private practice. Position involves directing a 15-bed medical-surgical unit and provide consultation to psychiatric staff. Contact Superintendent, Mental Health Institute, Independence, Iowa 50644; ph 319/334-2583. Equal Opportunity Employer. 12/81; 1-2/82

Grow with us in the Sunbelt. The INA Healthplan needs physicians in family practice and most specialties in Miami, Tampa, Dallas, Phoenix, Tucson, and Los Angeles. Attractive salaries and comprehensive benefits including professional development, retirement, and profit sharing programs are provided. If team interaction and casual living interest you, send a brief CV to Medical Administration, INA Healthplan, Inc, 7616 LBJ Freeway, Suite 303, Dallas, Tex 75251. 12/81; 1-2/82

Emergency Physician-Wausau, Wisconsin. Fee-for-service corporation with excellent income and benefits. New facility with excellent backup of all specialties. Generous time off to enjoy this family and sportsman's paradise. Emergency Medicine or Family Practice residency or Emergency Medicine Board certified required. Send CV or call Fred Klemm, MD, 2404 Hawthorne Lane, Wausau, Wis 54401; ph 715/842-9373. p11-12/81/1-82

Pediatrician to join 13-man multispecialty group. Many corporate benefits. Rapidly growing community of 25,000 located 30 miles north of Milwaukee. New hospital facilities. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. 9tfn/79

Family Practice, Internal Medicine and Pediatric positions available with an 18-member multispecialty group corporate practice. Modern clinic facility in Northeastern Wisconsin city of 100,000 enjoying a healthy and stable economy. Excellent recreational, educational, hospital, civic advantages. Please call collect or write: W J Mommaerts, Clinic Manager, West Side Clinic, SC, 1551 Dousman St, Green Bay, Wis 54303; ph 414/494-5611. 9-12/81

Attractive Emergency Room Opportunity. Lake Geneva area. Day shifts. Guaranteed minimum. Contact William Lange at Lakeland Hospital. Phone 414/723-2960. 9tfn/81

Family Practitioner to join a 50-physician multispecialty group with an 11-man Family Practice Department. Several challenging opportunities available in satellite practice. Initial guaranteed salary and excellent fringe benefits available. City of 50,000 on the Mississippi River. Outstanding place to live, work, and enjoy varied cultural and recreational opportunities. Contact: Medical Director, Skemp-Grandview-La Crosse Clinic, 815 S 10th St, La Crosse, Wis 54601; ph 608/782-9760. 11-12/81; 1/82

Family Practice. General Clinic—Jackson. Two family physicians for the Jackson Branch of a 12-man multispecialty clinic which includes (5) family practitioners, (4) internists, (2) pediatricians, and a general and vascular surgeon. Located 25 miles north of Milwaukee in a fast growing scenic area. Modern 120-bed hospital. Inquire: General Clinic of West Bend, Inc, 279 South 17th Ave, West Bend, Wis 53095. Phone: 414/338-1123. 11tfn/80

Two Family Practice Physicians sought to assume a fully operational practice in a community 30 miles north of Madison, Wisconsin. New clinic facility. Income guaranteed. Physician back-up available. Board certified or eligible preferred. Contact John P Rahm, MD, 6105 Ridgewood Ave, Madison, Wis 53716. 5tfn/81

OB/GYN Specialists. Enjoy the security of group practice with the freedom of independent practice. If you are Board Certified or Board Eligible in OB/GYN, we have an interesting opportunity for you. Two specialists are needed immediately to form an independent OB/GYN practice in a very desirable northern Wisconsin community with a drawing population of 70,000. Active practice assured. All major specialists available for consultation. Business and technical advice will be provided. Outstanding personal benefit programs available. Good income potential. New 35 million dollar hospital. For further information write: Administrator, PO Box 1646, Wausau, Wis 54401. 12/81*

Family physician, Board Certified or Eligible, to join four-man family practice group in northwest Wisconsin. First-year guaranteed salary. New clinic building located adjacent to 46-bed hospital, in the heart of Wisconsin's vacationland. Call shared with other family practice physicians in area, weekend coverage contracted. Jeanne Chamberlain, Adm, Spooner Clinic Ltd, 707 Ash St, Spooner, Wis 54801. Ph 715/635-2151. 12/81-5/82

Fond du Lac—26 physician incorporated multispecialty group on the south shore of Lake Winnebago needs a fourth pediatrician. Guaranteed salary with full shareholder status available after one year. Send CV to Kirk A Veit, MD, 80 Sheboygan St, Fond du Lac, Wis 54935. 9tfn/81

Medical Facilities

Green Bay, Wisconsin new prime office space across from new St Mary's Hospital. Lease or purchase options. Dr J Van Miller, phone 414/499-4241. 12tfn/79

For Sale: Eau Claire, well equipped and maintained medical office. Near downtown, on bus line; eleven hundred square feet; waiting room, private office, four examining rooms, laboratory. Ground floor, parking in rear. Rented four room and bath apartment above. General practitioner retiring after thirty years. Large patient following. Selling building and equipment. General practitioners needed. Contact: George E Wahl, MD, 616 E Grand Ave, Eau Claire, Wis 54701; ph 715/835-8038. 10 tfn/81

Family Practice. Established, independent practice in equipped office. Small city in recreational area. Continued care of patients main interest. Contact: KL Haman, MD, 199 South Division, Waupaca, Wis 54981; ph 715/258-2707. 11tfn/81

Immediate solo practice available in Jefferson, Wisconsin, due to the recent death of Richard H Siedenburg, MD. Expandable building with three large lots available. Lease or purchase. Contact Miller Law Office, PO Box 417, Jefferson, Wisconsin 53549; ph 414/674-3345. g11tfn/81

Milwaukee Internal Medicine Group wishes to share its downtown or Bayside well-equipped office space with any medical specialty. Contact: Administrator at 414/271-6800. 11-12/81

Port Washington, Wisconsin. New prime office space in professional building. Upper level already occupied by three internists (specializing in cardiology), one dentist, and three doctors of chiropractic. Lower level has 700-2500 sq ft. Area needs obstetrician-gynecologist, pediatricians, urologist, dermatologist, and general practitioner. Phone 414/375-3010 or 414/284-0500 or write 1032 S Spring St, Port Washington, Wis 53074. 12/81; 1-2/82

For Sale—office lease and practice. Death of physician necessitates rapid sale of this active solo general practice. On west side of Milwaukee's metro area. Arrangements negotiable. Contact L C Boryc DDS; ph 414/781-9585. 12/81; 1/82

Prime east Madison medical office space to share. 2000 sq ft. Fully equipped and well furnished. Private office and sound proof examining rooms. X-ray, lab, and physical therapy facility on premises. Equipped minor surgery room. Share rent and staff expenses on a 50-50 basis or prorated to your needs. For more information and appointment to view facility, call C A Gencheff, DO: 608/241-3451. 12/81-1/82*

Miscellaneous

Physician's Assistant seeks relocation. Have national-Wisconsin state certification. Experience in rural primary care and general surgery. Prefer small community or rural family practice in Southeastern Wisconsin. Resume and references upon request. Contact Dept 494 in care of the Journal. 9tfn/81

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Package Boiler Burner Service 39
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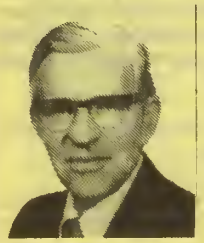
SMS Services, Inc 11

Real Estate

For Sale. Cottage. Wild Rose, Wisconsin. South-facing with 150 feet lake frontage on one of the best fishing lakes in the area. Front deck offers the best view on the lake. Surrounded by woods. Some of the best hunting and fishing in state, and a good ski hill 5 minutes away. Call 612/894-6076. 12tfn/81

CONSULTANT FOR FLORIDA REAL ESTATE



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Meetings/CME Courses

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals, Clinics, Specialty Societies, and Medical Schools are particularly invited to utilize this listing service. There is no charge for listing of meetings or courses held in Wisconsin; other listings will be made at the discretion of The Editors at the following rates: 40¢ per word, with a minimum charge of $16.00 per listing. BOXED LISTINGS: $32.00 per column inch. COPY DEADLINE for Continuing Medical Education listings is tenth of the month preceding the month of publication; e.g., copy for the August issue is due by July 10. Address communications to: Wisconsin Medical Journal, Box 1109, Madison, Wisconsin 53701; or phone (area code 608) 257-6781; or toll-free in Wisconsin: 800/362-9080. For listing of other meetings see the Special issue of the Journal of the American Medical Association: Continuing Education Courses for Physicians for period Sept 1, 1981 through Aug 31, 1982.

WISCONSIN

JANUARY 18-20, 1982: *New Therapeutics II: The Results of Recent Advances in Medicine*, Telemark Lodge, Cable. Sponsored by University of Wisconsin School of Medicine and Department of Continuing Medical Education. Approved 14 credit hours of Category I of AMA/AAFP. Fee: $215. Info: Ann Bailey, CME, 454 WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2854.

JANUARY 27-29, 1982: *12th Annual Winter Refresher Course for Family Physicians*, at The Pfister Hotel and Tower, Milwaukee. Sponsored by Department of Family Practice, Medical College of Wisconsin, and the Southeast Chapter of the Wisconsin Academy of Family Physicians. Approved 20 credit hours of Category I of AMA-PRA and AAFP. Info: Mrs Susanna Rechlitz, Conference Manager, Dept of Family Practice, Seton Tower, 2315 N Lake Dr, Milwaukee, Wis 53211; ph 414/291-0813.

FEBRUARY 3-5, 1982: *Ninth Annual North Central Wisconsin Clinical Cancer Conference*, Telemark Lodge, Cable. Sponsored by Marshfield Clinic, Marshfield Medical Foundation, American Cancer Society, Wisconsin Division, Inc, and Minnesota Division, Inc. This program is designed to review medical problems related to cancer and their treatment. Approved 7¾ credit hours of Category I AMA-PRA; 7¾ credit hours WAFP. Fee: $50. Enrollment limited to first 100 registrants. Info: Office of Medical Education, 1000 North Oak, Marshfield, Wis 54449; ph 715/387-5207.

FEBRUARY 9-11, 1982: *Nineteenth Annual Telemark Symposium and Ski Outing*, Telemark Lodge, Cable. Sponsored by the Indianhead Chapter of the Wisconsin Academy of Family Physicians. Approved six credit hours Category I of AMA-PRA and AAFP. Info: Robert H Herzog, Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122; ph 414/784-3656.

FEBRUARY 25-28, 1982: Wisconsin Psychiatric Association, Lake Lawn Lodge, Lake Delavan.

FEBRUARY 26-27, 1982: *Clinical Genetics for Primary Care Physicians*, Madison. Sponsored by Department of Medical Genetics, University of Wisconsin; and Continuing Medical Education, University of Wisconsin-Extension. Credit: AMA Category I, AAFP, AOA. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

FEBRUARY 27, 1982: Wisconsin Dermatological Society, UW Center for Health Sciences, Madison.

MARCH 4-5, 1982: *First Annual Symposium on Chronic Obstructive Pulmonary Diseases*, Madison. Sponsored by Continuing Medical Education, Health and Human Services Area, University of Wisconsin-Extension; the Pulmonary Section, School of Medicine; and the Department of Nursing, University of Wisconsin, Madison; and the Respiratory Therapy Department, Center for Trauma and Life Support, Center for Health Sciences, University of Wisconsin, Madison. Thirteen credit hours Category I of AMA; AOA, Wisconsin Nurses Association and Family Practice credit applied for; University of Wisconsin-Extension 1.3 CEUs. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

MARCH 25-26, 1982: *6th Annual Ophthalmology Current Concepts Seminar '82*, at Inn on the Park Hotel, Madison. Sponsored by University of Wisconsin, School of Medicine, Dept of Ophthalmology; and University of Wisconsin-Extension, Dept of Continuing Medical Education. Credit applied for Category I of AMA-PRA. Fee: $155. Info: Sarah Z Aslakson, Continuing Medical Education, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

APRIL 30-MAY 1, 1982: Wisconsin Urological Society, Concourse Hotel, Madison.

MAY 5-7, 1982: *Fifth Annual Cardiac Rehabilitation Symposium*, Red Carpet Inn, Milwaukee. Sponsored by Mt Sinai Medical Center, Milwaukee; University of Wisconsin-Extension, Dept of Continuing Medical Education; American Heart

STATE MEDICAL SOCIETY OF WISCONSIN
Dates and Locations of Annual Meetings
1982-1992

All meetings will be held in Milwaukee at the Milwaukee Exposition and Convention Center and Arena (MECCA) and the new Hyatt Regency as the headquarters hotel with the exception of 1985, when the meeting will be held at the LaCrosse Convention Center.

1982—May 13-15	**1987—Mar 26-28**
1983—Mar 24-26	**1988—Apr 28-30**
1984—Mar 29-31	**1989—Apr 13-15**
1985—Apr 25-27	**1990—Apr 26-28**
1986—Apr 17-19	**1991—Apr 18-20**
1992—Apr 23-25	

Meeting days will be Thursday and Friday; the first session of the House of Delegates will convene on Thursday, the second and third on Friday. Scientific programming will be on Friday and Saturday.

Further information: Commission on Continuing Medical Education, State Medical Society of Wisconsin, Box 1109, Madison, Wis 53701. Local telephone: 257-6781; toll-free in Wisconsin: 1-800/362-9080.

Association, and American College of Sports Medicine. Approved 25 credit hours of Category I AMA; AOA Category 2-D, University of Wisconsin Continuing Education Units. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

MAY 23-25, 1982: Wisconsin Chapter, American Academy of Pediatrics, Playboy Club, Lake Geneva.

JUNE 17-23, 1982: *Fifteenth Annual Postgraduate Course in Gynecological Pathology, Cytogenetics and Endocrinology,* Pfister Hotel and Tower, Milwaukee. Sponsored by The Medical College of Wisconsin, Milwaukee. Fee: $500 enrollment fee will include 68 selected 35mm slides. Approved 42 credit hours of Category I of AMA-PRA and AAFP. Info: Richard F Mattingly, MD, Medical College of Wisconsin, 8700 West Wisconsin Ave, Milwaukee, Wis 53226.

JUNE 16-19, 1982: Annual Scientific Assembly of the Wisconsin Academy of Family Physicians, Radisson Hotel, La Crosse. Approved 20 credit hours Category I of AMA-PRA. Info: Robert H Herzog, Wisconsin Academy of Family Physicians, 850 Elm Grove Rd, Elm Grove, Wis 53122; ph 414/784-3656.

JUNE 24-25, 1982: *Obstetrical Events and Neonatal Brain Injury,* Wisconsin Center, Madison. Sponsored by Continuing Medical Education, Health Sciences Unit, University of Wisconsin-Extension and Departments of Family medicine and Practice, Pediatrics, Gynecology and Obstetrics, School of Medicine, University of Wiconsin, Madison, and Madison General Hospital and St Marys Hospital Medical Center. Twelve credit hours, AMA; AOA; CEU's ACOG applied for. Info: Sarah Z Aslakson, CME, 465B WARF Bldg, 610 Walnut St, Madison, Wis 53706; ph 608/263-2856.

JULY 23-24, 1982: Wisconsin Society of Obstetrics and Gynecology, Leathem Smith Lodge, Sturgeon Bay.

SEPTEMBER 9-10, 1982: Wisconsin Surgical Society, La Crosse.

SEPTEMBER 9-12, 1982: Wisconsin Society of Anesthesiologists, Concourse Hotel, Madison.

SEPTEMBER 9-11, 1982: Wisconsin Society of Internal Medicine and American College of Physicians joint meeting, Holiday Inn Downtown, Green Bay. Info: Kim Marggraf, Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, Wis 53202.

OCTOBER 16, 1982: Wisconsin Radiological Society, Concourse Hotel, Madison.

OTHERS

JANUARY 21-26, 1982 (Louisiana): American Academy of Orthopaedic Surgeons, New Orleans. C V Heck, MD, Executive Director, 444 N Michigan Ave, Chicago, IL 60611.

FEBRUARY 1-5, 1982 (Colorado): *Eighth Stanford-Palo Alto Medical Research Foundation Winter Course in Infectious Diseases,* Aspen. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

FEBRUARY 11-14, 1982 (Arizona): *Newer Concepts and Approaches to the Diagnosis and Management of Coronary Artery Disease,* Scottsdale. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

12th ANNUAL WINTER REFRESHER COURSE FOR FAMILY PHYSICIANS

January 27-29, 1982 at The Pfister Hotel and Tower, Milwaukee, Wisconsin

The Department of Family Practice, The Medical College of Wisconsin, and Southeast Chapter of the Wisconsin Academy of Family Physicians.

This three-day course will cover topics in Diabetes, Cardiology, Obstetrics, Gynecology, Adolescent Medicine, and clinical updates in Rheumatology, Peripheral Vascular Disease and Pneumococcal Disease.

Accepted for 20 credit hours Category I AMA-PRA and AAFP.

Fee: $175. Course Director: Louis R Rosin, MD Associate Professor of Family Practice.

Info: Mrs Susanna Rechlitz, Conference Manager, Dept of Family Practice, Seton Tower, 2315 North Lake Dr, Milwaukee, Wis 53211. Phone: 414/297-0813.

WISCONSIN SPECIALTY SOCIETY MEETINGS: 1982

Wisconsin Psychiatric Association, Feb 25-28, 1982, Lake Lawn Lodge, Lake Delavan

Wisconsin Dermatological Society, Feb 27, 1982, UW Center for Health Sciences, Madison

Wisconsin Urological Society, Apr 30-May 1, 1982, Concourse Hotel, Madison

Wisconsin Chapter: American Academy of Pediatrics, May 23-25, 1982, Playboy Club, Lake Geneva

Wisconsin Academy of Family Physicians, June 16-19, 1982, Radisson Hotel, La Crosse

Wisconsin Society of Obstetrics & Gynecology, July 23-24, 1982, Leathem Smith Lodge, Sturgeon Bay

Wisconsin Surgical Society, Sept 9-10, 1982, La Crosse

Wisconsin Society of Internal Medicine, Sept 9-11, 1982, Holiday Inn (Downtown), Green Bay

Wisconsin Society of Anesthesiologists, Sept 9-12, 1982, Concourse Hotel, Madison

Wisconsin Radiological Society, Oct 16, 1982 Concourse Hotel, Madison

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SPECIALTY SOCIETY MEETINGS TO BE HELD IN CONJUNCTION WITH SMS ANNUAL MEETING, May 13-15, 1982, Milwaukee

Wisconsin Allergy Society
Wisconsin Orthopaedic Society
Wisconsin Society of Internal Medicine
Wisconsin Society of Pathologists
Wisconsin Society of Physical Medicine and Rehabilitation
Wisconsin Society of Plastic Surgeons
Wisconsin Society for Preventive Medicine
Wisconsin Society of Radiation Oncologists
Wisconsin Surgical Society

OTHERS

FEBRUARY 12-21, 1982 (Tahiti): The medical specialties of French Polynesia invite all Wisconsin physicians to a Continuing Medical Education Program. Sponsored by the State Medical Society of Wisconsin. Info: State Medical Society of Wisconsin, PO Box 1109, Madison, Wis 53701; ph 1-800/362-9080.

FEBRUARY 22-26, 1982 (Colorado): *Third Annual Conference on Problems in Gastroenterology: A Clinical and Pathological Approach,* Keystone. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

MARCH 1-2, 1982 (Michigan): *6th Annual Winter Pediatric Seminar,* Caribou Lodge, Powderhorn Ski Area, Bessemer, Michigan. Sponsored by Marshfield Clinic and Marshfield Medical Foundation. Approved 8 credit hours of Category 1 of AMA-PRA and AAFP. Fee: $60. Registration deadline, Feb 22, 1982. Info: Marshfield Clinic's Office of Medical Education, 1000 N Oak Ave, Marshfield, Wis 54449; ph 715/387-5207.
g11-12/81; 1/82

MARCH 8-12, 1982 (Hawaii): Sports Medicine Postgraduate Course, Maui, Hawaii. Approved 25 credit hours of Category 1 AMA-PRA. Info: Bates Noble, MD, Course Director, Northwestern University Center for Sports Medicine, 303 East Chicago Ave, Chicago, IL 60611. g11/81

MARCH 13-20, 1982 (Mexico): *Seventeenth Annual Clinical Conference* of the Marquette-Medical College of Wisconsin Alumni Association, Camino Real Hotel, Ixtapa, Mexico. Approved 20 credit hours of Category 1 AMA-PRA. Info: Robert H Herzog, Marquette-MCW Medical Alumni Association, 8701 Watertown Plank Rd, Milwaukee, Wis 53226; ph 414/257-8367.

APRIL 28-30, 1982 (Indiana): *Endocrinology and Diabetes for the General Internist,* Indianapolis. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

MAY 16-20, 1982 (Brazil): *The Fifth International Symposium on the Prevention and Detection of Cancer, San Paulo, Brazil.* Sponsored by Fundacao "Centro de Pesquisda de Oncologia" and The International Society for Preventive Oncology; Info: Medical Congress Coordinators Department, 1212 Avenue of the Americas, New York, NY 10036; ph 212/840-0110. g8-12/81; 1-4/82

JUNE 2-4, 1982 (Illinois): *Problem Solving in Lung Disease: A Practical Approach,* Chicago. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

JUNE 14-16, 1982 (Canada): *Critical Care Medicine-1982,* Banff, Alberta. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

RESUSCITATION: PITFALLS, PEARLS & PROMISES
Feb 3-5, 1982, La Posada Resort
Scottsdale, Arizona
Distinguished national faculty will head program focused on three vital organ systems: heart, lungs and brain, with special emphasis on newest techniques for minimizing organ damage. 18 hours Category I applied for through ACEP, AAFP & AMA-PRA. Info: AzACEP, 810 W Bethany Home Rd, Phoenix, AZ 85013; ph 602/246-8901. 12/81

JUNE 17-19, 1982 (Texas): *Review of Internal Medicine-1982,* Houston. Info: Registrar, American College of Physicians, 4200 Pine St, Philadelphia, PA 19104.

AMA

FEBRUARY 25-28, 1982: AMA National Leadership Conference, Downtown Chicago Marriott, Chicago, Ill.

JUNE 13-17, 1982: Annual AMA House of Delegates, Downtown Chicago Marriott, Chicago, Ill.

DECEMBER 5-8, 1982: Interim AMA House of Delegates, Miami Beach, Fl. ■

Bookshelf

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

1981 USP DI (United States Pharmacopeia Dispensing Information). Publications Dept, 12601 Twinbrook Pkwy, Rockville, Md 20852. 1981. Pp 1163.

Nutrition and Medical Practice. Editor, Lewis A Barness, MD with Yank D Coble Jr, MD; Donald I Macdonald, MD; George Christakis, MD. Avi Publishing Company, Inc, 250 Post Road East, Westport, Conn 06881. 1981. Pp 408. Price: $19.50.

Scorpions of Medical Importance. By Hugh L Keegan. University Press of Mississippi, 3825 Ridgewood Rd, Jackson, MS 39211. 1980. Pp 140. Price: $22.50.

Clear Skin. By Kenneth L Flandermeyer, MD. Little, Brown and Co, Boston, Mass 02109. 1979. Pp 211. Price: $5.95. ■

MIDWEST Regional CME meetings
American College of Physicians

FEBRUARY 26-27, 1982 (Kansas): Hilton Inn, Wichita. Info: Max S Allen, MD, FACP, University of Kansas Medical Center, 39th St & Rainbow Blvd, Kansas City, KS 66112.

MARCH 26-27, 1982 (Nebraska): Hilton Hotel, Lincoln. Info: Bowen E Taylor, MD, FACP, Box 81009, Lincoln, NE 68501.

APRIL 29, 1982 (North Dakota): Westward Ho, Grand Forks. Info: Harold W Evans, MD, FACP 2624 Olson Dr, Grand Forks, ND 58201.

JUNE 4-5, 1982 (Iowa): University of Iowa, Iowa City. Info: William B Galbraith, MD, FACP, 115 8th St, NE, Cedar Rapids, IA 52401.

SEPTEMBER 9-11, 1982 (Wisconsin): Holiday Inn Downtown, Green Bay. Joint meeting with WSIM. Info: Kim Marggraf, Wisconsin Society of Internal Medicine, 611 East Wells St, Milwaukee, WI 53202.

MEMBERSHIP FACTS

ARE YOU A MEMBER of the State Medical Society of Wisconsin, or do you know someone who isn't? Whether you're just starting medical school, maintain a full-time practice, or are retired, SMS has a membership classification to fit your individual needs. Furthermore, in light of a recent change in membership policy, physicians may join their county and state societies and the AMA or just their county and state societies; however, AMA membership is encouraged. Dues for regular membership are $410 for SMS, $285 for AMA, and county society dues vary. A more detailed listing of SMS membership classifications and their corresponding dues follows:

State Medical Society of Wisconsin

DESCRIPTION OF DUES CLASSIFICATION CODES

Regular: Member in active practice. Some are regular members that have reduced SMS and/or AMA dues because they are new practitioners (first year or two out of residency).

Resident: Physician who at January 1 of dues year is in an approved training program as a hospital resident or research fellow who is licensed to practice medicine and surgery in Wisconsin.

Military Service: Members who are serving in the U.S. armed forces (generally not to exceed five years).

Associate: Member whose dues are waived because of illness or financial hardship. This classification is temporary and is reviewed on an annual basis.

Life: Member who has held membership in a state medical society for 50 years or is a Past President of the State Medical Society of Wisconsin.

Honorary: Member who was named by the Board of Directors in recognition of long and distinguished service to the cause of medicine.

Retired: Member who has completely retired from practice (works less than 240 hours per year). All dues are waived unless county society indicates they wish to charge county dues.

Part-time Practice: Physician, regardless of age, who practices 1,000 hours or less during the calendar year but does not qualify for retired membership.

Over Age 70: Member in active practice who is over 70 years of age.

Candidate: Member attending a medical school in Wisconsin or fulfilling a postgraduate obligation prior to eligibility for licensure.

Scientific Fellow: Member who is engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine or Osteopathy.

Emeritus: Retired members who have chosen not to renew their license.

1982 DUES AMOUNTS FOR THESE CLASSIFICATIONS

	SMS	AMA	COUNTY
Regular	$410	$285	Normal County Dues
Resident	41	35	Varies
Military Service	-0-	285 or 35	-0-
Associate	-0-	-0-	-0-
Life	-0-	-0-	-0-
Honorary	-0-	-0-	-0-
Retired	-0-	-0- *	-0-
Part-time Practice	205	285 *	Normal County Dues
Over Age 70	205	-0- *	Normal County Dues
Scientific Fellow	-0-	-0-	
Emeritus	-0-	-0-	
Candidate—			
Freshman Year Medical Student	-0-	15	Varies
Sophomore and Succeeding Medical Student Years	10	15	Varies
Postgraduate—One	10	35	Varies

*Due to recent policy changes by the AMA, future exemptions from AMA dues will be given to those physicians who are over 70 years of age *and* are retired from practice or practice 1000 hours or less a year.

1981-82 Membership Directory to be published in January

The 1981-82 Membership Directory will be published in January for the second consecutive year. It will have the same format: State Medical Society members will be listed alphabetically by county medical society and will include the member's name, address, telephone number (if provided), and primary and secondary specialties. Last month all members received a postal card with a computer-printed label as provided by the Membership Department. Members are asked to confirm the information on the label and make any corrections (including the telephone number and county medical society), returning the card to the *Wisconsin Medical Journal*; changes will continue to be made until press time, but no later than December 31, 1981. To contain costs the WMJ will not include other editorial matter in the directory issue. Because of the nature of the issue additional advertising space will be offered to medical clinics, hospitals, and other patient care services.

By EARL THAYER, Secretary / BERNIE MARONEY, Assistant Secretary

Special

PERSONAL FINANCIAL PLANNING.

Several good tips for a better personal financial plan were given by a highly qualified faculty at a recent seminar sponsored by SMS Services, Inc. Here's a summary—check with your own attorney or CPA on whether or how these can work for you:

- The 1981 Tax Act provides for:
  - —Individual Tax rate reductions
    - 1981 . . . . . 5%
    - 1982. . . . . .10%
    - 1983. . . . . .10%

    withholding rates change accordingly.
  - —Maximum Tax rate reduced to 50% in 1982.
  - —Reduction in maximum Capital Gains tax rate to 20% in 1982.
  - —Accelerated Cost Recovery System (Depreciation) of business property and equipment, but be careful. You may end up paying more taxes upon sale than you saved by using this method. Think ahead.
  - —Participants of qualified retirement plans can, effective 1982, also defer income through an IRA.

- Maximizing after tax dollars with real estate and other tax shelters.

- Other tax-saving techniques through corporations, gifts, and trusts for children, and charitable contributions of appreciated assets. (This year [1981] may be a good time for charitable contributions. Don't forget the Society's CES Foundation.)

- Techniques and methods of analyzing investment real estate for rate of return, inflation hedge, cash flow, and appreciation potential.

- Estate Planning
  - —Everyone should have a will.
  - —Avoid probate (at least in part).

- Some Estate and Gift Tax Provisions of the 1981 Tax Act effective January 1, 1982:
  - —The highest estate and gift tax rates are reduced from 70% to
    - 65% in 1982
    - 60% in 1983
    - 55% in 1984
    - 50% in 1985 and subsequent years.
  - —The Unified Credit is increased from $47,000 to $192,000 over six years to equal a $600,000 estate tax exemption in 1981 and subsequent years.
  - —All current limits on the marital deduction are deleted. CAUTION: Substantial unnecessary federal tax can be incurred if this is not handled properly.
  - —The annual gift tax exclusion is increased from $3,000 to $10,000 per donee and is unlimited for gifts of school tuition and certain medical expenses.
  - —All existing wills should be reviewed and updated prior to January 1, 1982.

- Maximum Contributions to Keogh (HR-10) Plans will increase from $7,500 to $15,000 in 1982 with the 15% of earnings limit still applicable.

- Constructive Receipt—Under current law a participant in a qualified retirement plan is taxed on benefits distributed or made available to him. Effective January 1, 1982 the "made available to him" part will be eliminated.

- IRS is prohibited from issuing final regs on taxation of fringe benefits until December 31, 1983.

- Advantages of Living Trusts—Offers privacy, not filed in probate court, may be less probate cost, funded during lifetime, less administration, less susceptible to will contest, may save taxes.

Because of the very positive response from past attendees, SMS Services, Inc intends to sponsor seminars on these general topics again in 1982. Watch for the announcement. Meanwhile, tear out this page and ask your lawyer or CPA to look it over for ways it might help you.

—Prepared by Lee A Johnson, Director of Administrative Services, State Medical Society. ■

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